



## JUVENILE REHABILITATION INTEGRATED TREATMENT MODEL

Legislative Report



Washington State Department of  
**CHILDREN, YOUTH & FAMILIES**

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In accordance with Engrossed Substitute Senate Bill 6168 Section 225(3), this report is in response to the Legislature's request for an evaluation of the Department of Children, Youth and Families Integrated Treatment Model.

(m) \$200,000 of the general fund—state appropriation for fiscal year 2020 is provided for the department to measure the fidelity of the evidence-based interventions incorporated into the integrated treatment model. By July 1, 2020, the department must report to the Governor and the appropriate fiscal and policy committees of the Legislature on the results of the assessment of the integrated treatment model.

## About Juvenile Rehabilitation

Juvenile Rehabilitation (JR) became part of Washington State's Department of Children, Youth, and Families (DCYF) on July 1, 2019. JR serves the state's highest-risk youth who have been charged with a qualifying offense and either adjudicated in a county's juvenile court or convicted in an adult criminal court. As the state moves away from institutionalizing youth and the youth crime rate declines, JR has gone from an average daily population in 1998 of 1,272, to 402 in 2019, an almost 68% decline in 20 years. Many of the youth who have historically been served at JR are now receiving local sanctions. This change has resulted in a changing profile of youth (i.e. higher proportion of high-risk youth) committed to JR. As of 2019, JR runs three institutions and eight community facilities. Youth start at an institution, then, depending on risk level, sentence, suitability and bed availability, can be moved to a community facility before being released. About half of JR youth receive community supervision (parole) when they are released from residential care.

## The Integrated Treatment Model

In 1999<sup>1</sup>, JR implemented a competency-based treatment and case management model. The model focused on increasing youth accountability, skill development and measuring youth changes in skill areas throughout their stay in the JR continuum of care.

In 2000, JR needed to further define and specify the appropriate interventions with both the individual youth in residential care and subsequently in families as the youth returned to their home communities. JR formed the Integrated Treatment Model (ITM) Workgroup, charged with the task of developing a research-based treatment model that utilized cognitive-behavioral principles. The model was to be tailored for use in both residential and community settings in the juvenile justice continuum of care. Goals for the model included:

- Research-based effectiveness
- Motivation and engagement of both youth and families
- A commonly understood language to be utilized throughout the juvenile justice continuum
- A uniform set of cognitive-behavioral skills
- The ability to generalize and maintain positive changes
- Ongoing clinical consultation system to ensure the continuity of the interventions and adherence to the model

The workgroup's report was finalized in 2002 and the process of implementing the ITM began. This model views all behavior, including a youth's criminal behavior as occurring in a larger social and historical context,

<sup>1</sup> This section is adapted from the Executive Summary of the original ITM Report from 2002.

serving a specific function. As such, criminal behavior is a product of one's learning history, encompassing family dynamics, specific circumstances and thoughts and feelings.

For example, in residential care (state institutions and community facilities) the model focuses on improving the skills of the youth who are separated from their family and removed from the community context in which their behavior occurred. Assessment of the criminal and other undesirable behavior uses a behavioral analysis to identify the contextual variables and the function of the behavior. Using basic behavioral change techniques of shaping, reinforcement, extinction and contingency management, the therapist implementing the model engages the youth in the change process, targets behavior using a hierarchy system and then teaches the youth specific behavioral skills to change their actions, thoughts or feelings. Much of the theoretical basis of the residential treatment component of the ITM is based on the researched-based treatments of Cognitive Behavioral Therapy (Linehan, 1993), Aggression Replacement Training (Glick, Goldstein, and Gibbs, 1998), and Moral Reconation Therapy (Little and Robinson, 1988), although the latter has never been fully implemented.

Once a youth leaves residential care and moves back into the community, the context of their behavior changes. The ITM reflects this difference. In community settings, where youth are monitored while on parole, the primary focus shifts to creating a more functional environment within the family where the youth resides. Again, research on maintaining and supporting behavior change for at-risk adolescents indicates intervention is most effective if supported within a family context. Parole staff work with families to shift the "problem behavior" to a relational issue between family members. The primary theoretical underpinnings for this section of the model come from Functional Family Therapy (Alexander and Parsons, 1982; Sexton and Turner, 2010), a research-based family intervention. At the onset of the ITM (early 2000s), all youth received some level of parole supervision; at the time of this report (2020), only about 50% of youth leaving a JR residential facility receive some form of community supervision.

Since its original inception in 2002, the ITM has evolved to include a risk and needs assessment called the Integrated Treatment Assessment (ITA) as well as other assessments that help determine placement, treatment needs, and facility and parole eligibility. The main residential treatment model is Dialectical Behavior Therapy (DBT) and the main parole treatment model is Functional Family Parole (FFP) with Functional Family Therapy (FFT) for those with high needs. Aggression Replacement Training (ART) is another treatment offered to eligible youth in the institutions. Additionally, there are Specialized Sex Offender Treatment (SOT), Substance Use Disorder (SUD) treatment and Mental Health (MH) treatment available in the institutions. Rounding out the ITM, there are protocols in place for suicide and self-harm prevention. The goal is this array of assessments and treatments are integrated and aligned using a Risk-Need-Responsivity (RNR) framework. The RNR framework is comprised of three principles. First the "risk principle," which suggests that those with the highest risk for reoffending should be prioritized for treatments and other interventions. Second, the "need principle" recommends that the individual needs of each youth are determined, specifically those needs that are most likely to be associated with criminal behavior. Third, the "responsivity principle" requires that the correct type of programming be offered based on an individual's risk and need profile (Crites and Taxman, 2013; Brogan, Haney-Caron, NeMoyer, and DeMatteo, 2015).

In 2009, a study was conducted by The Washington State Department of Social and Health Services, Research and Data Analysis Division (Lucenko and Mancuso, 2009), that compared outcomes for JR youth from before and after the ITM was implemented. Allowing a two-year period to fully implement the ITM, the study compared state fiscal year 2002 outcomes to 2006, for youth who were released from JR. The study found

that employment rates for JR youth increased by 34% and re-arrest rates declined by 10%, coinciding with the implementation of the ITM. While parts of the ITM have been evaluated for their effectiveness over the years, there has yet to be an assessment of the implementation of the ITM as a comprehensive treatment model.

Starting in early 2016, an internal JR committee (called the ITM Reboot Committee) convened to start integrating a Positive Youth Development (PYD) framework into the ITM and to examine ITM implementation issues. The three main priorities identified by the committee were to improve and streamline training, clarify supervision standards, and update quality assurance tools. The committee finalized its findings in early 2018 and JR leadership has been working since then to address the issues raised by the committee.

### Current Study

In 2019, the Washington State Legislature allocated funds for a fidelity assessment of the ITM in DCYF's Juvenile Rehabilitation. To accomplish this task, the DCYF Office of Innovation, Alignment and Accountability (OIAA) collaborated with external experts to assess the current implementation fidelity of the treatment areas in the ITM. The following treatment areas of the ITM were identified as part of the current assessment:

1. Assessment System
2. Dialectical Behavior Therapy (DBT)
3. Functional Family Parole (FFP)/Functional Family Therapy (FFT)
4. Aggression Replacement Training (ART)
5. Specialized Sex offender Treatment (SOT)
6. Substance Use Disorder Treatment (SUD)
7. Specialized Mental Health Treatment (MH)
8. Suicide and Self-Harm Prevention (SSP)

For the assessment system, the consultants were asked to address questions related to the appropriateness, quality and monitoring of the assessments used to inform the ITM. The specific questions can be found in Appendix A. For all the treatment areas, the consultants were asked to address questions related to treatment quality, integration and monitoring. The specific questions can be found in Appendix B. The consultants reviewed available policies and documentation, studied the available published literature and conducted site visits at JR facilities and parole offices before providing their expert responses to the questions. All the original consultant reports can be found in the Appendix C through J. Below, we summarize the findings across all the treatment areas and provide recommendations for JR's ITM moving forward.

### Main Findings on Current ITM Implementation

Here we present first the findings that apply to the ITM as a whole, and then we summarize the area-specific findings. Overall, there are four main findings from this study. First, consultants consistently reported that JR has passionate and motivated staff, however, in many cases they are being asked to work outside of their job description or are not adequately trained for the job they are being asked to complete. Second, the JR organizational structure often impedes effective treatment integration and delivery. Third, the assessment system lacks oversight and has not been effectively integrated into treatment eligibility and dosage decisions. Fourth, there are inconsistent quality assurance and implementation monitoring practices across JR's integrated treatment model.

## Finding One: Staff Are Passionate, but Not Adequately Trained

Across treatment areas, consultants noted the dedication and compassion of JR staff. The interaction between youth and front-line staff is the key to effective implementation of the ITM. Having dedicated staff is essential to provide a quality treatment model. Dedicated staff, however, are not sufficient. Nearly all the consultants mentioned staffing issues, including high turnover, low pay, staffing levels and lack of training. Staff must be supported and adequately trained for the treatment to produce the desired outcomes. Importantly, JR recently completed a staffing study for both the residential facilities and parole services. The findings from those two studies are relevant here and confirm the findings from the consultants in this study.

Some of the relevant findings from the residential staffing model study include: (1) “The current number of staff and composition of the workforce cannot support full implementation of all the components of the Rehabilitation Model,” (2) “Staff do not receive the necessary training time to gain requisite knowledge and skills for working with youth. In addition, training is not always provided in a timely manner.” (3) “Actual turnover and turnover intent of staff are significant issues.” (4) Line-level staff “all appear to be ‘under classified’ and underpaid relative to other positions with similar qualifications and responsibilities” (Hyzer Group, 2019a). Additionally, the parole services staffing model studies concluded that the current model “does not account for the time to conduct the range of necessary reentry services youth require in order to successfully reenter their homes and communities. The current model also does not account for the time parole counselors spend with youth who are still in residence” (Hyzer Group, 2019b).

Taken together, from the current report and the extensive staffing model studies that were completed last year, it is clear that the supports (number of staff, staff pay and training) do not match the expectations required of the treatment model. This imbalance is likely driving the high staff turnover rates, which exacerbates the staffing challenges.

## Finding Two: JR Organizational Structure Impedes Effective Treatment

Juvenile Rehabilitation offers an array of treatment options, and currently most of the important treatment areas for effective rehabilitation are present, at some level. However, there are a number of occasions where it is evident that the organizational structure is inhibiting effective integration of treatment. Currently, there is no clear oversight structure for the Integrated Treatment Model. Treatment administrators are spread throughout the organization and do not have direct authority over how treatment is administered. In short, the ITM has never been fully integrated, and the agency is not attending to the on-going process of integration.

The agency is teaching youth many skills through different treatments. For example, DBT, ART and FFP all have a full set of skills and many youth will be exposed to all three sets of skills. While there are commonalities across these treatments, each contains distinct elements and there is little to no attempt to help youth understand how all these sets of skills are related. This is largely due to the fact that staff have not been trained on all the sets of skills being presented throughout the ITM. Youth will not be able to generalize the skills they have learned – the therapeutic step where the youth implements these skills in their own life – if staff are not trained to reinforce the skills while they are in JR.

## Finding Three: Assessment System Lacks Oversight and Is Not Integrated Into Decisions

The JR assessment system is currently using assessment instruments that have not been validated.<sup>2</sup> Additionally, there is no oversight of the assessments being used to make important treatment and residential housing decisions. This lack of oversight could result in differential assessment results and differential access to services depending on who conducted the assessment. Finally, the assessments are generally not integrated into treatment decision-making (i.e. the assessment does not directly inform the type of treatment needed or dosage of treatment). Too often treatment is being determined by which facility a youth is placed at, and the interventions available at that location, instead of the RNR principles.

## Finding Four: Inconsistent Monitoring of Treatment Quality

There is a patchwork of quality assurance practices across JR's ITM. In some treatment areas, there are full-time staff who conduct observations and provide a highly reliable assessment of the residential environment (for example DBT environmental adherence assessments), while in other areas, very little quality assurance has been implemented (substance abuse treatment, see Appendix H and other DBT treatment modes, see Appendix D). Additionally, for most of the treatment areas, the treatment administrator is also responsible for providing the quality assurance monitoring. This creates a situation where the treatment administrators are being asked to provide objective monitoring of their own program, which is contrary to best practice in quality assurance. The result is inconsistent, and in many areas, inadequate, quality assurance protocols across the ITM.

## Treatment Specific Findings

### Summary of Assessment Findings

The ITM relies on one risk and needs assessment, called the Integrated Treatment Assessment (ITA) and three actuarial risk assessments, the Risk Assessment-Recidivism (RAR), Risk Assessment-Institution (RAI) and Risk Assessment-Community Facility (RACF). These four assessments are not subjected to oversight and do not have a governance structure. None of them have been validated locally using a JR sample.

“Of the four instruments the ITA holds the greatest potential to drive case planning, youth classification (on risk and need), treatment models and the assessment of change over time. While the ITA does provide a great deal of important information, it does not appear that it is currently integrated into the treatment model as much as it could be. For example, treatment activities are driven largely by [living unit] placement, which appears to be driven by procedures that do not involve the ITA to a substantial degree. Overall, the potential for the ITA is not currently being realized” (Holsinger and Holsinger, 2020 – see Appendix C for the full assessment system report).

### Summary of Dialectical Behavior Therapy (DBT) Findings

“The intention [of JR] to provide DBT to fidelity is deeply rooted – from the behaviorally specific DBT standards for each DBT mode to the sophisticated and rich intranet of DBT resources to aid in its delivery. Staff shortages and staff turn-over have significantly compromised JR’s ability to train up its workforce in DBT and to maintain

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<sup>2</sup> The only evidence that the items in the assessments are associated with the outcomes come from the construction sample, from when the assessments were created. In order for the instruments to be considered validated, the instruments need to be tested using a sample that is different from the one used to create the assessments.

whatever training gains it makes. Non-competitive wages make it particularly challenging to recruit personnel at all levels (AA, BA, MA, PhD). The situation is even more dire in rural areas.

Training, consultation and supervision resources are insufficient to meet the actual demand that counselors have in order to fulfill the DBT standards and deliver DBT to fidelity. In contrast to the early years of DBT implementation at JR where staff attended intensive trainings with ample consultation from other JR DBT experts, the trainings are now limited to two and three-day trainings and very limited consultation. Staff shortages have made it difficult for new staff to attend the trainings that are offered.”

“The DBT standards accurately capture what a gold-standard JR system should seek to do... With respect to the individual delivery of DBT... the majority of today’s counselors have not had enough training to know how to deliver DBT individual counseling to fidelity” (Dimeff, 2020a – see Appendix D for the full DBT report).

### **Summary of Functional Family Parole (FFP) Findings**

Currently only about half of youth released from JR residential facilities receive some level of aftercare/parole services. About half who receive parole do so because they committed a qualifying offense, the other half are eligible because they score in the highest 25% on a JR risk assessment. The risk assessment used to determine parole eligibility has not been validated. “Without validation, the accuracy of placements is unknown and significant numbers of youth may be underserved due to scores that result in no JR parole placement upon reentry into their communities, while many other youths at lower risk may be placed” on parole. “It is likely that a significant number of non-placed youth are in need of monitoring and have significant reentry needs for services that would be best provided by JR parole [aftercare].”

“The treatment quality of FFP appears more variable, relative to FFT quality, ranging from low for FFP counselors with seemingly limited commitment and fidelity to the FFP approach and moderate for counselors who seem to have embraced the FFP model and appear motivated to implement FFP with integrity. Hampering treatment quality for FFP is the inadequacy of training, beyond the initial FFP training, the supervision structure, and fidelity monitoring procedures” (Waldron, 2020 – see Appendix E for the full FFP report).

### **Summary of Functional Family Therapy (FFT) Findings**

“As a whole, the FFT therapists appear to be performing at a uniformly exemplary level, given the restricted resources available to them. Without exception, all of the FFT therapists participating in the site visits associated with this report demonstrated the high levels of knowledge and skills required for effective FFT implementation. Treatment dosages for youth and families who receive FFT appear quite good, with number of therapy sessions and rates of treatment retention and completion for FFT providing solid indicators of FFT quality.”

“The structure of placing FFT therapists in the role of [clinically] supervising FFP counselors is detrimental to both FFT and FFP implementation quality because FFT therapists are responsible for overseeing FFP fidelity for counselors who do not directly report to them and who are formally supervised by others who conduct their performance evaluations. This situation gives FFP counselors the option to follow or reject the guidance of FFT therapists, limiting the impact of therapists’ time and skills. ...FFT quality is also diminished somewhat by the lack of systematic training for all therapists in all elements of the ITM” (i.e. DBT and ART), (Waldron, 2020 – see Appendix E for the full FFT report).

## Summary of Aggression Replacement Training (ART) Findings

JR uses the Integrated Treatment Assessment (ITA) to determine eligibility for ART. “None of the research reviewed indicates that the current eligibility criteria is predictive of future violent behavior, which would require ART as an appropriate treatment. The current program is using an assessment for eligibility, and the assessment is being used appropriately, however, JR has not determined that the eligibility criteria that have been selected are appropriate.”

“JR appears to be implementing the treatment according to the design. There are strong training and quality assurance protocols in place. In terms of dosage, all those who start the program receive the same dosage, which is three sessions per week for 10 weeks. It is not clear whether youth are receiving the right dosage. It is likely that some youth require more treatment and some less, however, the current design of ART does not allow for this type of dosage variation...There was some reporting that ART is only allowed 45 minutes for sessions in some places due to school schedules. This would result in a lower dosage than intended. There is variation by location in terms of when ART is administered, but the standards and quality assurance for the program is consistent across location” (Fox, 2020 – see Appendix F for the full ART report).

## Summary of Specialized Sex Offender Treatment (SOT) Findings

“The DCYF program, particularly as delivered in its inpatient facilities, emphasizes a strong skills-based approach using empirically supported treatments such as Dialectical Behavior Therapy and Aggression Replacement Training... Case notes reflected treatment plans, which in turn reflected the medical and/or psychiatric evaluations from which they were drawn as well as the legal documents for each youth. Case notes were generally well written and the treatment plans themselves reflected and enabled an individualized treatment approach for each youth in treatment... On balance, there is much to be proud of within this branch of DCYF services.

The number one concern expressed by all interviewed is that the treatment provided within the inpatient components [DBT and ART] of the program is not provided by licensed clinicians. Although the programs are assisted by psychologists, the treatment itself is delivered by people who do not have specialized training in psychotherapy... The second most cited concern is staff turnover”<sup>3</sup> (Prescott, 2020 – see Appendix G for the full SOT report).

## Summary of Substance Use Disorder (SUD) Treatment Findings

“It does not appear that youth are being appropriately matched with treatment based on need. While there is a range of levels of care provided across the institutions, each institution only provides one or two levels of care that may be dependent on what substance is being used.

Assignment of youth to particular institutions is made based on multiple considerations, including age, gender, sentence length and other considerations, of which SUD prevalence/severity is not one. Youth in need of SUD treatment get the level of treatment offered at the institution to which they were remanded, regardless of

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<sup>3</sup> Specialized sex offender treatment for youth in state community facilities and for youth on parole supervision are provided through contracted services from community providers.

their level of need/severity. In many cases, this means youth get less treatment than they need, in some cases, more treatment than they need and in other cases, no treatment at all.”<sup>4</sup>

“JR appears to be implementing the chosen treatments as well as possible given the constraints of the settings. Treatments are generally manualized and delivered in the context of an individualized treatment plan. Staff are passionate about providing high quality SUD care. However, systemic issues interfere with the ability of JR to provide optimal treatment. For example, it was noted that staffing was often a problem. As noted, at the time of the site visit, Echo Glen Children’s Center (EGCC) was not providing intensive outpatient due to staffing challenges. As long as this is the case, no girls in a JR institution receive SUD treatment... There was no formal quality assurance plan identified at any of the sites visited” (Stoner, 2020 – see Appendix H for the full SUD treatment report).

### **Summary of Special Mental Health (MH) Treatment Findings**

“While all of the mental health treatment providers were clearly motivated, compassionate and conscientious, they also all reflected on the inadequacy of the system (lack of sufficient staff, high complexity of needs) for delivering high quality mental health treatment. Neither approach (short term or through the entire term) appeared to be guided by symptom reduction (with the exception of TF-CBT which could be extended if youth symptoms were not resolving).”

“A strength of mental health treatment across all institutions is the effort to coordinate the medical and psychosocial treatment of mental health needs through team-based planning and ongoing coordination. Treatment plans are reviewed with mental health therapists, coordinators, psychiatrists and medical directors in the three institutions.”<sup>5</sup>

“Mental health therapists serving youth in the JR institutions are not being routinely trained in best practice clinical treatment standards. The fellowship rotation at Echo Glen ensures a number of youth have access to treatment by residents who are being exposed to evidence-based treatment strategies through other rotations but training for JR therapists is otherwise limited to what the clinician was trained to do prior to hire and whatever clinical strategies they are motivated to learn more about as part of their ongoing clinical education. The treatment approach is generally eclectic and therapists are being called upon to address a very wide range of needs without adequate training and consultation support... There did not appear to be a quality assurance plan for monitoring the treatment of specific mental health disorders” (Walker, 2020 – see Appendix I for the full Specialized MH Treatment report).

### **Summary of Suicide and Self-Harm Prevention (SSP) Findings**

“The policy that governs the procedural practice of assessing, managing and treating suicidal and self-harming youth is comprehensive, sophisticated, and contains numerous safeguards to ensure each at-risk youth’s situation is carefully assessed. All staff working with youth are required to complete multiple trainings on suicide and self-harm prevention... This training is very thorough, comprehensive, and is likely more than most licensed clinicians receive in graduate school. Brilliantly, employees are expected to study and memorize risk

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<sup>4</sup> Substance use disorder treatment for youth in state community facilities and for youth on parole supervision are provided through contracted services from community providers.

<sup>5</sup> Specialized mental health services for youth in state community facilities and for youth on parole supervision are provided through contracted services from community providers.

and protective factors *before* arriving at their training... These training approaches are sophisticated and rigorous."

"The treatment plan to address suicidal and non-suicidal self-injurious behavior requires sophisticated behavioral procedures that are contained within Dialectical Behavior Therapy (DBT)... Staff shortages and staff turn-over have significantly compromised JR's ability to train up its workforce in these and other procedures and to maintain whatever training gains it makes. Non-competitive wages make it particularly challenging to recruit personnel at all levels (AA, BA, MA, PhD). The situation is even more dire in rural areas. Without staff retention and comprehensive training, consultation and supervision [related to DBT], it is difficult how counselors can be expected to actually *implement* an effective treatment plan that reduces suicide and self-harm risks. Blocking procedures and the [Suicide Precaution Level] SPL procedures will ensure that those at risk in the moment do not have access to lethal means and methods to cause self-injury or death by suicide. This is different, however, than having a carefully developed treatment plan...that will serve them well after they leave JR" (Dimeff, 2020b – see Appendix J for the full SSP report).

## Finding a Path Forward: Recommendations

The goal is to create an ITM that can work effectively today, and that can also expand as additional resources are added. The basic JR ITM approach is sound, however, significant improvements to integration and implementation are needed. Many of the recommended changes to the ITM can be made without additional funding. The agency must focus on treatment implementation, which includes having the correct eligibility criteria, high quality treatment and providing the correct dosage based on the client's level of need. As implementation improves, we expect that this will have a direct impact on improved outcomes. There are numerous treatment area-specific recommendations in the assessments located in the full consultant reports, which are provided in the Appendix, and a list of some of the top area-specific recommendations can be found in the table at the end of this section. For those interested in a specific treatment area, we encourage you to read the assessment report on that treatment. Experts wrote these comprehensive and insightful reports. The following recommendations are seen as the top priorities to improve JR's ITM implementation.

### Recommendation 1: Realign Organizational Structure to Create Clear ITM Oversight

This recommendation is the top priority. The remaining recommendations are not likely to be successful without a clear oversight and management structure for the ITM. DCYF should re-align the organizational structure to create a clear decision making process and monitoring of the ITM. This includes a more clear plan for how DCYF will align QA practices, treatment options and assessment in support of the ITM. The current structure, where treatment administrators are spread throughout the agency and there is no clear oversight or accountability of assessments (recommendation 2) or treatment quality (recommendation 5), is hindering the agency's ITM implementation. Further, under the current structure there is no clear process in place to correct the issues that have been identified in this report. A defined organizational structure that prioritizes treatment will provide the structure for an accountable and transparent process to be implemented. DCYF should take this opportunity to define what integrated treatment means, and better align the resources necessary for an efficient, effective and culturally responsive treatment model. By aligning the treatment resources, the agency will be in a better position to create an ITM with feedback loops for continuous improvement and monitoring.

JR has selected the ITM as its strategy to rehabilitate youth. The organizational design should support that strategy. The first step in operationalizing this recommendation should be a more formal assessment of how

the strategy, structure, processes, rewards and people are all aligned, or misaligned. This can be done through a STAR model assessment to determine if the agency is designed to accomplish its goal of effective treatment and rehabilitation (Galbraith, 2014).

The more appropriate organizational structure would view treatment through the lens of the ITM and RNR principles. Where youth are being assessed, highest risk youth are prioritized and youth are being matched with treatments based on their needs. Treatment access should not depend on the facility the youth is placed in. Instead, the youth should be placed in the facility that can best meet the youth's treatment and other needs. By realigning the JR organizational structure, which should include the integration of assessment, QA and treatment oversight into the broader DCYF plan, the treatment model can move forward with the tasks of integration, monitoring and refinement that are outlined in the consultant reports. An integrated and realigned organizational structure would include one person (or a clearly defined and empowered committee) who is ultimately accountable for the ITM implementation. They would oversee all the treatment administrators, and the implementation and oversight of the risk and needs assessments (recommendation 2). Further, the ITM oversight structure would also provide the clinical oversight for those providing case management (recommendation 4).

### **Recommendation 2: Create an Accountability Structure for Risk and Needs Assessment**

There has never been a full integration of the assessments and the treatment programs in the JR ITM. First, there needs to be a process of identifying and prioritizing the top needs of a youth when they enter custody. Every youth's top treatment needs should be identified during the initial intake process, and then referrals made for both the treatment type and the dosage needed for each youth. As part of this process, eligibility criteria for all the treatment options and dosage levels needs to be clearly established and routinely tested. The assessment process, and clearly matching youth to the appropriate treatment, is essential for their future success.

The fact that JR continues to use risk assessment tools that have not been validated is a major concern. All risk assessments that make decisions about youth care must be routinely validated and tested for reliability. DCYF should identify or develop an administrative position or function to oversee assessments. "The new administrative position would oversee new and ongoing training for existing (and newly adopted) assessments. The position would also be responsible for conducting quality assurance reviews of case plans derived from assessment activities insuring that they are driven by the RNR (Risk Need and Responsivity) principles. Likewise, the position would oversee regularly scheduled tests of validity for all assessments in use, as well as efforts to ensure acceptable levels of interrater agreement and interrater reliability, and would also oversee the adoption and implementation of a standardized responsivity assessment process. Under the assumption that assessment activities should drive, and be integrated with the treatment models, the Director [or Administrator] of Assessment would be ultimately responsible for making sure that true integration occurs. Assessment procedures are the cornerstone of any effective intervention model, and as such the integrity of the information that is gathered, the way the information is used and the extent to which the information undergirds every part of the system is paramount" (Holsinger and Holsinger, 2020 – see Appendix C).

No matter how the agency decides to oversee the assessments, all assessments, particularly those used to make decisions related to facility placement and length of incarceration, should be routinely validated.<sup>6</sup> “[The RAR, RAI, RACF] continued use should be based in large part on both the results of tests of predictive validity as well as the overall agency objectives” (Holsinger and Holsinger, 2020 – see Appendix C).

### **Recommendation 3: Provide Transition Support to All Youth Leaving Residential Facilities**

In the recently released DCYF draft strategic plan, one of the agency priorities is to “create successful transitions into adulthood for youth and young adults in our care.” This successful transition for JR youth is largely dependent on the successful process of reentry from a residential facility back into the community. The reentry planning process begins right when youth are admitted to a JR facility. It is paramount that JR support the successful transfer and maintenance of gains made by youth while under residential supervision (e.g. treatment progress, education improvement and housing stability) into the community setting (including the Child Welfare system).

Parole is an important component of successful community reentry. About half of youth released do not have any support from JR when they are released from a residential facility and transition back into the community. Even without additional resources, JR should consider how all youth might receive community supports.

“Although this would require a systemic change at the legislative level, such a change could be initiated at a minimal level without an increase in funding... Monitoring and providing services to [all JR] youth would also likely result in substantial savings to the state through decreased recidivism and reincarceration. Although attempting such a change without an increase in funding would not produce optimal results, the empowering of JR parole to allocate resources across the single continuum of need would help guide the application of current resources more efficiently” (Waldron, 2020 – see Appendix E).

“Supervising all youth transitioning to the community would double the overall number of youth served, but would not require a doubling of the workload for JR parole staff. A substantial number of lower risk youth would need less monitoring and could be supervised with monthly FFP check-ins and brief phone contacts. Similarly, youth with moderate risk, including those who would have been placed in JR parole and those who would have been released without JR parole placement, could be supervised with bi-weekly FFP check-ins, with phone contacts as needed, while higher risk youth could receive services as they are now provided by JR parole. Allowing adjustments in length and intensity of service to be made internally by JR parole, based on validated assessments, would significantly enhance the efficiency and effectiveness of services across all youth. Because all youth not placed in JR parole are released from incarceration with some arrangement for housing, funding for housing services would not necessarily need to increase” (Waldron, 2020 – see Appendix E).

JR, with the support of the Legislature, must find innovative ways to ensure all youth can transition smoothly into the community. For example, all youth have a residential sentencing range and are required to spend a minimum amount of time in a residential facility. The time between the minimum and maximum sentencing range could be seen as the transition period. After the minimum date, JR could begin to transition the youth back to their home community, with parole services and electronic home monitoring, returning the youth back to a facility if they violate certain rules. The important factor here is that all youth need support as they

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<sup>6</sup> Through this ITM assessment process, DCYF has engaged the external consultants to begin risk assessment validation work of the RAR, RAI, and RACF.

return to their community and JR should not release youth from an institution directly back to the community, without some level of support for a successful transition. This process must be guided by data and the research on what is most effective.

### **Recommendation 4: Transition to “DBT for Some,” and Develop Specialized Therapists in Residential Facilities**

It is clear that adjustments are needed so that youth receive the services outlined by agency standards, particularly related to the main residential treatment model, DBT. Although there are staffing issues such as turnover and staffing levels that need to be addressed, there are changes the agency can make now to implement DBT in a manner that enables JR professionals to provide higher quality treatment to youth. Specifically, JR should transition to providing full DBT only to those who need it the most. Second, JR should begin transitioning toward specializing responsibility for providing individual counseling sessions and skills groups. Staff are not adequately trained to administer the treatment and turnover is high. It takes a significant amount of resources to sufficiently train staff to effectively perform their job duties and many leave before they are proficient.

As outlined by Dimeff (2020a, Appendix D), “JR should reconsider comprehensive DBT for some (vs. comprehensive DBT for all). It is a noble effort to seek to provide comprehensive DBT for all youth, particularly in light of the real challenges to hiring and retention of staff. While DBT for all may be the ideal, it may also not be affordable (and therefore realistic). It is better to provide comprehensive DBT to those who need it the most rather than “DBT Lite” for all. Clear criteria could easily be established to determine those who most need DBT counseling to fidelity. A small cohort of clinicians/counselors could then be trained and supervised to ensure they have the capability of providing DBT to fidelity in the individual counseling mode. All other residents could receive DBT Lite (EA, DBT skills). Those selected to provide 1:1 DBT to fidelity may also have additional incentives to tackle work with the most difficult of youth (e.g. more training opportunities, opportunity for more competitive wages, protected time for consultation team).”

DBT can be a valuable treatment, however, not all youth need it and certainly not all youth need the same dosage. This decision to attempt to give everyone adherent DBT has resulted in very few youth actually receiving the treatment with high quality (Fox, Miksicek and Veele, 2019).

Next, JR should have specialized therapists provide DBT and case management. JR is asking too many staff to take on too many tasks. Currently, JR expects staff to be proficient in three of the four DBT treatment modes: coaching on the floor, individual sessions and skills groups. The training requirements are significant in order to bring a staff up to speed in all three areas. It might take years for a professional to develop proficiency in all modes. Consequently, staff are providing DBT modes without sufficient training and quality improvement support. They are leading skills groups with insufficient training in DBT skills and group management; coaching youth on the floor without enough training in behaviorism and goal-directed coaching; and conducting individual sessions without sufficient training in engagement, motivation and behavior change strategies. The current implementation strategy is not producing the quantity or quality of treatment necessary for effective DBT treatment dosage. This recommendation will help improve treatment for youth in JR and will, hopefully, align workers’ expectations with their compensation (Hyzer Group, 2019a).

Leadership should focus and specialize the scope of responsibilities for the current job classifications within JR, and consider adding a classification for specialized staff who provide individual counseling, case management and reentry planning. As an example, the staff with specialist classification would be responsible for a larger individual counseling caseload, and would have limited or no duties managing the floor. This group of

specialists will receive intensive training in DBT case management and reentry support. Having DBT provided by a specialist would allow others in the living units to focus solely on coaching youth and managing the living unit environment. The specialists would be accountable to the ITM oversight structure (see recommendation 1).

The agency could realize cost savings by targeting specific training and quality assurance activities with smaller groups of specialists based on their scope of responsibility. Training everyone on everything remains a significant logistical and financial challenge. Tailoring and prioritizing trainings for targeted specialists (therapists, group facilitators, and coaches) will accelerate competency and mastery, resulting in a multitude of benefits to the agency, facilities, employees and clients. This new approach could contribute to increased staff morale and retention by empowering and supporting staff to focus their development, with considerably more targeted and direct support. Staff specialization will allow staff to feel more capable once they are able to master their responsibilities.

### **Recommendation Five: Adopt a Uniform and Clear Quality Assurance Program Across the ITM**

Currently, there is a lack of consistent monitoring of treatment implementation. In the absence of data, it becomes difficult to create a system of accountability and transparency. To that end, JR needs to create a uniform quality assurance and continuous quality improvement model for the ITM. Currently, the ITM Quality Assurance team is only dedicated to conducting QA for a portion of DBT. In order to monitor the ITM, so that agency leadership can see both the quality and quantity of treatment being delivered, the new QA structure should include a number of key features. First, a treatment dashboard needs to be developed. Data on both treatment need and treatment access could be monitored in near real time. Second, the role of quality assurance should be seen as separate from program oversight. Often the administrator for the program or program area is also the same person who provides quality assurance monitoring. This creates a situation where treatment administrators are being asked to report on the quality of their own work. Third, JR needs a more routine and standardized quality assurance process. Currently, each program in the ITM has a different QA structure and reporting process. QA needs to be consistent so that changes over time can be identified, but it also has to be feasible given the limited resources. JR should explore the Standardized Program Evaluation Protocol (SPEP) or a similar standardized tool that will allow for the routine monitoring of programs with the same set of protocols.

There is significant institutional knowledge among JR staff about what works, and what does not work, for treatment and rehabilitation of juveniles. The youth in JR have many treatment needs and are at high risk for future offending. Because of this, an efficient system of assessment that informs treatment prioritization is essential. Leadership (both within the agency and the Legislature) must ensure that our most valuable asset, the staff, are supported by a system that is designed for success. This will result in lower recidivism, fewer victims and youth leading lives that are more successful in the long term. The adoption of the recommendations listed in this report will move JR into a new phase of treatment implementation that is more effective, efficient and data-driven.

## Top Area-Specific Recommendations From Consultant Reports

Recommendation Number*	Focus Area	Recommendation
C.1	Assessment system	Develop a point person (e.g. a Director [Administrator] of Assessment) or function and a small administrative structure that would be dedicated solely to implementing, monitoring and driving everything related to the system's assessment procedures.
C.2	Assessment system	The continued use of the RAR, RAI and RACF should be based in large part on the results of their tests of predictive validity.
C.3	Assessment system	If the RAR, RAI and RACF do possess current predictive validity, consider utilizing them as instruments that dictate intensity of supervision and/or the intensity of the residential placement.
C.4	Assessment system	Give priority to the ITA in order to drive more aspects of the treatment model currently in place. Ensure that the ITA and the information that it renders is fully understood and utilized by any and all staff that work with the youth in any capacity.
D.1	Dialectical Behavior Therapy (DBT)	Reduce staff shortage and improve retention. Staff shortages make it difficult for staff to attend trainings and have the necessary time to do what is required well.
D.2	Dialectical Behavior Therapy (DBT)	Reconsider comprehensive DBT for some (instead of attempting DBT for all)
D.3	Dialectical Behavior Therapy (DBT)	Offer comprehensive, intensive training in DBT over the course of a year.
E.1	Functional Family Parole (FFP)	Parole could have a far greater impact if each region maintained oversight and supervision of <i>all</i> youth re-entering their communities.
E.2	Functional Family Parole (FFP)	A more rigorous fidelity monitoring measure is needed to improve the quality of FFP.
E.3	Functional Family Parole (FFP)	Additional FFP counselors are needed at all sites to improve the frequency and duration of FFP sessions with youth and families.
E.4	Functional Family Therapy (FFT)	Funding is needed to increase FFT and FFP staff salaries.
E.5	Functional Family Therapy (FFT)	Provide additional resources to FFT therapists for travel.
E.6	Functional Family Parole (FFP)/Functional Family Therapy (FFT)	Develop checklists, procedures and/or benchmarks to monitor cross-site consistency of FFP and FFT implementation.

## JUVENILE REHABILITATION INTEGRATED TREATMENT MODEL

E.7	Functional Family Parole (FFP)/Functional Family Therapy (FFT)	Allow all FFT therapists and FFP counselors to attend or “audit” ongoing trainings for DBT and ART.
E.8	Functional Family Parole (FFP)/Functional Family Therapy (FFT)	Add capacity to conduct data analyses to monitor program performance (treatment quality, quality assurance, FFT and FFP outcomes) internally.
F.1	Aggression Replacement Training (ART)	Refine the ART eligibility criteria so that it is based on evidence accumulated over the past 10 years of implementation, and then focus ART on those with the greatest need and the highest risk.
F.2	Aggression Replacement Training (ART)	Reconsider how ART is being implemented to ensure a full hour for programming for ART sessions, to ensure implementation fidelity.
F.3	Aggression Replacement Training (ART)	Implement a process that allows for closely monitored variations of ART programming. For example, JR could test a shortened version of ART for youth who have the assessed need and are high risk, but do not have a very long sentence.
F.4	Aggression Replacement Training (ART)	Set up a curriculum review committee for ART, to make sure lessons can continually improve.
G.1	Specialized Sex Offender Treatment (SOT)	Advancements in the areas of trauma-informed care, motivational enhancement and the further development of approach goals would be welcome.
G.2	Specialized Sex Offender Treatment (SOT)	On-site clinicians for treatment provision in the residential programs would be ideal.
H.1	Substance Use Disorder Treatment (SUD)	Provide SUD treatment staff with a new title (and higher pay) that reflects their different role within the institutions.
H.2	Substance Use Disorder Treatment (SUD)	Continuity of care could be enhanced by providing SUD treatment records to community facilities when youth arrive there from institutions and to community treatment providers with whom paroled youth continue their treatment.
H.3	Substance Use Disorder Treatment (SUD)	Make regular use of a SUD treatment oversight committee to guide the implementation of SUD assessment and treatment in juvenile justice settings in the state.
H.4	Substance Use Disorder Treatment (SUD)	Each institution should provide multiple levels of care to better match youth to SUD treatment according to need.
H.5	Substance Use Disorder Treatment (SUD)	Funding for alternative curricula could also improve treatment quality if other treatments can be identified that better fit the constraints of correctional settings.
H.6	Substance Use Disorder Treatment (SUD)	Refresher training for providers in their treatment models could enhance fidelity. Curriculum review by credentialed treatment trainers could also be beneficial.

## JUVENILE REHABILITATION INTEGRATED TREATMENT MODEL

I.1	Specialized Mental Health Treatment (MH)	Restructure the delivery of mental health treatment to provide more stepped care approaches beginning with group-based treatment facilitated by mental health staff and then moving to one on one treatment for youth who continue to display consistent and concerning behaviors.
I.2	Specialized Mental Health Treatment (MH)	Improve clinical continuity by either a) involving regional mental health coordinators from the youth's home community; or b) improve telemedicine facilities.
I.3	Specialized Mental Health Treatment (MH)	Ensure mental health treatment plans and targets of therapy are integrated in milieu behavioral goals and planning by adapting current family system models to work with line staff in cottages and units.
J.1	Suicide and Self-harm Prevention (SSP)	Reduce Suicide & Self Screen (SSS) interview process. It is recommended that JR consider convening a task force comprised of all relevant stakeholders (including youth) and outside suicide experts to streamline the method.
J.2	Suicide and Self-harm Prevention (SSP)	Ensure adequacy of training for DBT core competencies. The only way a counselor will be able to actually treat that which they assessed using the SSS is by receiving comprehensive training in the treatment procedures, including ongoing consultation and supervision.
J.3	Suicide and Self-harm Prevention (SSP)	Carefully consider providing Designated Suicide Prevention Specialist (DSPS) option to deviate from standard procedure.
J.4	Suicide and Self-harm Prevention (SSP)	Consider having a designated suicide expert available for more complex cases and to conduct quality assurance review of SSS.

\* The letter before the recommendation number indicates the appendix where the full report can be found. Please see the full consultant reports for more details on each of these recommendations.

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## Appendices

**Appendix A:** List of questions related to ITM assessment system

**Appendix B:** List of questions related to ITM treatment areas

**Appendix C:** Fidelity Assessment of ITM Assessment System  
by Dr. Alex Holsinger and Dr. Kristi Holsinger

**Appendix D:** Implementation Assessment of Dialectical Behavior Therapy  
by Dr. Linda A. Dimeff

**Appendix E:** Implementation Assessment of Functional Family Therapy and Functional Family Parole  
by Dr. Holly Barrett Waldron

**Appendix F:** Implementation Assessment of Aggression Replacement Training  
by Dr. Andrew M. Fox

**Appendix G:** Implementation Assessment of Treatment for Youth Who Sexually Offend  
by David Prescott

**Appendix H:** Implementation Assessment of Specialized Treatment for Substance Abuse  
by Dr. Susan A. Stoner

**Appendix I:** Implementation Assessment of Specialized Mental Health Treatment  
by Dr. Sarah C. Walker

**Appendix J:** Implementation Assessment of Suicide and Self-Harm Prevention  
by Dr. Linda A. Dimeff

**Appendix A:** List of questions related to ITM assessment system

**Questions for Assessment System:**

1. Considering the JR assessment system, are the assessments appropriate and integrated with the treatment model?
2. Are youth being appropriately matched with treatment based on assessed risk and need?
  - a. What assessments are being used for program eligibility?
  - b. Are the assessments being used appropriately?
3. Does the current quality assurance plan adequately monitor assessment performance?
4. Please provide a statement of qualifications.
5. What recommendations do you have to improve the assessment system in JR, given the current level of resources?
6. What additional resources would you recommend to improve the assessment system and integration?
7. JR will be serving youth up to age 25 in the future. What advice related to the assessment system would you give the agency as they prepare to provide this treatment for older youth?
8. Please provide a statement of qualifications.

**Appendix B:** List of questions related to ITM treatment areas

**Questions for treatment categories:**

1. Are youth being appropriately matched with treatment based on need?
  - a. What assessment is being used for program eligibility?
  - b. Is the assessment being used appropriately?
2. Is the treatment high quality?
  - a. How well is JR implementing this treatment?
  - b. Are youth receiving the appropriate dosage?
  - c. Do staff receive the correct type and amount of training?
  - d. Does there seem to be variation by location? (between institutions, between institutions and community facilities)
3. How well is the treatment integrated with the assessments, other treatments, and reentry planning?
4. Does the current quality assurance plan adequately measure the treatment model?
5. Do you see any evidence that would concern you that treatment access varies by race, ethnicity, age, or gender?
6. What recommendations do you have to improve implementation given the current level of resources?
7. What additional resources would you recommend to improve treatment quality and integration?
8. JR will be serving youth up to age 25 in the future. What advice would you give the agency as they prepare to provide this treatment for older youth?
9. Please provide a statement of qualifications.

**Appendix C:** Fidelity Assessment of ITM Assessment System  
by Dr. Alex Holsinger and Dr. Kristi Holsinger

## **Fidelity Assessment of ITM/JR Assessment System**

**Alexander Holsinger, PhD**

**Kristi Holsinger, PhD**

**April 2020**

### **Executive Summary**

#### **Considering the JR assessment system are the assessments appropriate and integrated with the treatment model?**

The RAR, RAI, RACF and ITA served as the primary focus for this question. Each of the instruments were reviewed for face validity, item weighting, and scoring procedures with potential liabilities noted. Of the four instruments the ITA holds the greatest potential to drive case planning, youth classification (on risk and need), treatment models, and the assessment of change over time. The ITA is a lengthy and comprehensive assessment that measures a large number of relevant criminogenic domains in depth, offering both risk/need and protective factors. In addition, the ITA is conducted via a one-on-one interview as well as the review of official records and databases. The other three instruments are based largely on delinquent history, and do include some items from other relevant criminogenic domains such as substance use/abuse, but not to a degree that could drive an individual treatment model. While the three assessments may possess predictive validity (if their use is to continue new validation studies are recommended), their use is likely better served outside of a treatment environment (particularly in light of the potential for the ITA).

While the ITA does provide a great deal of important information, it does not appear that it is currently integrated into the treatment model as much as it could be. For example, treatment activities are driven largely by (pod/house) placement, which appears to be driven by procedures that do not involve the ITA to a substantial degree. Overall the potential for the ITA is not currently being realized.

#### **Are youth being appropriately matched with treatment based on assessed risk and need?**

As noted above, the ITA is not currently driving the treatment model to the extent that it could. Best practices in correctional interventions state that delinquent youth should be referred to effective criminogenic need-specific programming (e.g., cognitive behavioral interventions), and that the referrals should be based on a comprehensive dynamic risk/need assessment. In addition, youth should only receive programming that applies to their unique set of criminogenic needs. Further, responsivity factors should be assessed and utilized as well in order to match youth to programming and therapists that fit the youth best regarding their profile (e.g., learning style, motivation, readiness for change and other responsivity factors). Currently youth are being assessed by a psychologist who makes residential placements based on the information gathered. Residential placement in turn drives the treatment activities that occur. As a result, the link between criminogenic risk/need activities (e.g., via the ITA) and programmatic matching is not as strong as it could be.

**Does the current quality assurance plan adequately monitor assessment performance?**

Quality assurance activities are in place, but there is some room for improvement (though the improvement may be due to the need for additional resources – see below). Staff that conduct the ITA assessments go through a rigorous training led by a seasoned master trainer with an immense amount of experience using the ITA, as well as experience in relevant training activities. The initial training does include inter-rater agreement tests as well, that have revealed a high rate of agreement. The quality assurance activities would benefit from additional staff that could assist with one-on-one observation of staff that conduct the ITA on a regular schedule (e.g., once per year), “booster-session” trainings on a tri-yearly basis, and additional inter-rater agreement testing. In addition, the ITA should be subjected to a regularly occurring (e.g., every 3 to 5 years depending on circumstances) test of predictive validity using relevant and varied outcomes.

**What recommendations do you have to improve the assessment system in JR, given the current level of resources?**

- If the RAR, RAI, and RACF will continue to be used, consider limiting their use to other parts of the justice system. Their continued use should be based in large part on the results of their tests of predictive validity.
- If the RAR, RAI, and RACF do possess current predictive validity consider utilizing them as instruments that dictate intensity of supervision and/or the intensity of the residential placement.
- Give priority to the ITA in order to drive more aspects of the treatment model currently in place. Insure that the ITA and the information that it renders is fully understood by, and utilized by, any and all staff that work with the youth in any capacity.

**What additional resources would you recommend to improve the assessment system and integration?**

Consider developing a point person (e.g., a Director of Assessment) and a small administrative structure that would be dedicated solely to implementing, monitoring, and driving everything related to the system’s assessment procedures. The new administrative position would oversee new and ongoing training for existing (and newly adopted) assessments. The position would also conduct quality assurance reviews of case plans derived from assessment activities insuring that they are driven by the RNR (Risk Need and Responsivity) principles. Likewise, the position would oversee regularly scheduled tests of validity for all assessments in use, and would also oversee the adoption and implementation of a standardized responsivity assessment process.

Additional resources would also benefit the expansion of treatment and rehabilitative activities within the JR system. Additional treatment programming will likely be necessary in order to adequately address criminogenic needs, particularly if the ITA were used to more fully drive case planning and programmatic placement. In short, it is likely that a fuller utilization of the ITA will reveal the need for more treatment capacity. Additional resources for treatment programming should also include allowances for processes that will regularly and quantitatively assess the quality (i.e., integrity or fidelity) of the programming.

**JR will be serving youth up to age 25 in the future. What advice related to the assessment system would you give the agency as they prepare to provide this treatment for older youth?**

It will very likely be necessary to adopt, implement, and test the validity of a tool designed to assess the adult offender population. Tools such as the LSI-R, the COMPAS, the ORAS, or another comprehensive tool of sufficient breadth and depth that has a high degree of demonstrated predictive validity should be considered. Once adopted best practices in offender assessment as they relate to training, implementation, and tests of validity on the local population should be observed.

It is possible that portions of the ITA could be used on the young adult offender population, but it would be necessary to go to great lengths to ensure that the tool (and/or the portions therein) do indeed adequately predict the desired outcomes for young adult offenders aged 18 to 25.

## **Integrating assessment activities and information into treatment models: Washington State JR**

Submitted by Alexander M. Holsinger, Ph.D. & Kristi Holsinger, Ph.D.

In an effort to improve the treatment the Washington State Department of Children, Youth & Families (DCYF) provides to youth in Juvenile Rehabilitation (JR), the Washington State Legislature designated funding for a fidelity assessment of their Integrated Treatment Model (ITM). A significant component of the ITM is the Juvenile Rehabilitation Assessment System which relies on a variety of assessment instruments and practices that guide decision making for youth.

This report is the result of an extensive review of written protocols, published reports, descriptive data, and a site visit conducted in early January, 2020. Specifically, the researchers visited the Echo Glen Children's Center, the Green Hill School and JR headquarters, conducting information gathering sessions with a wide variety of stakeholders, directors, and staff. In this collaborative research, we provide our expert opinion and recommendations while addressing specific guiding questions, to assist in the work of moving to more efficient and accurate approaches in assessment.

### **Question 1: Considering the JR assessment system, are the assessments appropriate and integrated with the treatment model?**

An effective evidence-based assessment model that drives an effective correctional rehabilitative environment should embody three principles: Risk, Need, and Responsivity, or RNR. In short, the assessment activities as a whole should offer a valid and objective measure of quantitative risk (meaning how "at risk" a youth is, which refers to the likelihood they will engage in delinquent behavior in the future). The results of assessment procedures should also present professionals with each youth's unique criminogenic (crime-producing) needs. For example the correctional research literature has identified the comprehensive array of criminogenic needs that are directly related to a youth's willingness or compulsion to engage in delinquent behavior. As such assessment activities should present a profile unique to each youth that indicates which criminogenic needs are active factors within the youth and their environment (both physical, cognitive, and social). Assessment activities should also result in knowledge about what strengths and barriers may be active within the youth and/or their environment that may have a direct impact on their willingness or ability to engage in treatment activities. For example, motivation, treatment readiness, intelligence, and learning disabilities are all responsivity factors (though not an exhaustive list – see below for an expanded discussion regarding the principle of responsivity).

In addition to informing the principles of Risk, Need, and Responsivity, effective assessment models should involve the standardized and objective collection of dynamic items that in turn inform specific assessments and scales or scores that result. Dynamic items are those that are changeable (as opposed to static items, which do not change). For example, “how old were you when you first tried marijuana?” would be an example of drug use measured in a static way while “over the last six months what role has marijuana played in your life?” is an example of assessing the same domain in a dynamic fashion. The use of dynamic items and information is very important since they allow for the measurement of change over time, and via various intervention methods. Effective assessment models will facilitate the measurement of change over time, and offer treatment professionals an idea of whether a youth is making progress in treatment. Effective assessment activities should drive comprehensive and useful case planning, and should likewise drive placement in housing units, placement in various treatment programs, and should allow for appropriate and effective release planning as well. It is often necessary for youth to be assessed multiple times particularly when they are involved in treatment programming and/or living in residential facilities for extended periods of time (e.g., a year or longer).

Overall there appears to be room for improvement regarding the extent to which assessment activities in the State of Washington’s Juvenile Rehabilitation system are integrated into the broader treatment model. This report focuses primarily on the Risk Assessment – Recidivism (hereafter RAR), the Risk Assessment – Institution (hereafter RAI), Risk assessment – Community Facility (RACF), and the Integrated Treatment Assessment (ITA). The first three of the aforementioned assessments (RAR, RAI, RACF) were each designed for, and to some extent are used for, specific purposes. For example the RAR<sup>1</sup> utilizes several factors (several static, some dynamic) in order to assess the likelihood of post-release recidivism. The RAI was designed to determine the likelihood of a youth being placed within an intensive management unit once they are already within an institution. Like the RAR, the RAI is comprised of several items, some static and some dynamic. The RACF was designed to determine the likelihood a youth will return to an institution once they have been placed in a community-based facility.

#### *The RAR*

As noted above the RAR consists of some static and dynamic items, most if not all of which have at least some face validity regarding the statistical prediction of recidivism. The items largely assess factors that are of some use in a criminal justice/correctional setting. For example knowing whether or

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<sup>1</sup> The exact composition of the RAR differs for male and female juveniles, and as such special attention should be paid toward insuring gender bias in decision making does not result.

not an individual has a history of assault or facility non-compliance can be useful in making placement (e.g., housing, roommate) and other decisions. As a whole the information contained within the RAR is not broad nor deep enough in order to inform case planning or drive a treatment model. For example, substance use is an important domain to measure when delivering services to system-involved populations, and the RAR presents just one item scored as “none,” “impairment,” or “unknown.” While this item is informed/scored from other parts of the system, on its own this item is of little value in terms of an integrated treatment model.

Overall, the RAR might have some utility as a stand-alone assessment used to assess the likelihood of recidivism in some settings (e.g., after release to the community) depending on systemic objectives, but the extent to which a treatment model could be informed by the RAR is likely substantially limited. In addition, in the event the RAR continues to be used, attention should be paid to the way items are measured, and the weight they are given when contributing to the overall score. For example, it is very common for jurisdictions and legislatures to struggle greatly with the measurement of gang membership. Gang membership has a long history within the criminal justice literature and much evidence has shown it to be predictive of delinquent and criminal behavior. At the same time gang membership is something that can change over time as does what constitutes membership itself (vs. affiliation or association).

Another issue that may limit the RAR’s utility is the fact that different versions exist for male and female youth. There is support in the literature showing that criminogenic predictors may differ somewhat for male and female youth, perhaps in type, form, and importance (meaning weight). However some challenges to objectivity and fairness may emerge when different criteria and weighting are used for the same instrument that informs the same decisions. For example mental health needs are factored into the RAR female but not the RAR male. There is evidence that mental health needs are indeed prevalent in the male offender population (yet go unmeasured), but moreover, currently there is controversy regarding the inclusion of mental/behavioral health issues at all when it comes to the prediction of risk, particularly when decisions that affect how long someone might be confined or how closely they might be supervised are at stake. Mental and behavioral health are currently regarded more as a responsivity consideration as opposed to a risk factor or a criminogenic need. Likewise, the risk of suicide is included on the RAR female but not the RAR male. Further, the “SAVY (Aggressive or Not Vulnerable)” item is calibrated in a way that makes it possible to overwhelm the scoring scale entirely. The “SAVY” can contribute up to 80 points, while all the other items together max out at a total of 150

points. Having an item weighted so heavily within the context of the rest of the scored items runs the risk of negating the purpose of the risk assessment itself, entirely.

Recommendations:

- Reconsider the use of the RAR, particularly in light of other assessment processes that are in place.
- If it is determined that the RAR does have continuing potential utility, consider testing the validity of the tool overall using appropriate outcome(s) and a recent dataset.
- Statistical analyses should consider the utility of different versions based on sex and/or ethnicity.
- If possible statistical analyses should consider the use of other standardized items that display better predictive validity than one or more current items. Along similar lines consider replacing mental/behavioral health with another item, or eliminate it altogether particularly if the tool maintains predictive validity and differentiates levels of risk adequately (and likewise classifies youth into workable proportions) without it.
- The appropriateness of the weighting and scoring of items should be examined.

*The RAI*

As noted above, the RAI was developed in order to offer predictability regarding the likelihood a youth will be placed within an intensive management unit, once they have been placed in a facility to begin with. Importantly, the RAI should have utility when making placement and other decisions that relate to the level of oversight and monitoring of the youth. Ideally the RAI could be used as a risk assessment that supports staff decision making that reduces the likelihood isolation will be necessary. Intra-institutional placement is an important decision and ideally one that is based on statistically valid and objective criteria. It does not appear that the RAI could inform case planning or drive an integrated treatment model given a lack of breadth and depth regarding the domains that are captured via the instrument.

Like the RAR, the RAI contains several items that have at least face validity. For example, prior assaultive behavior, impulsivity, substance use, criminal history, prior within-facility behavior all have both face validity and support in the literature as predictors of institutional behavior. Most of the items are static (unchangeable) in nature, while some have dynamic properties. The items have been weighted in a manner so each contributes points relative to the conditions underlying the items. Based on prior

research, the RAI has demonstrated predictive validity and a statistical relationship with relevant outcomes (in this case, placement in an intensive management unit within the facility).

Like the RAR, the RAI might have some specific utility (in the case of the latter, the making of intra- or even inter-facility placement and housing decisions). Given the effort that goes into other assessment activities (e.g., the ITA) it might be possible to utilize other information that is being gathered prior to the scoring of the RAI in order to facilitate earlier decisions based on richer and more dynamic information. If it is determined that the RAI should remain in use, the following recommendations should be considered:

- Reconsider the use of the RAI, in exchange for portions of the ITA.
- If it is determined the RAI does have remaining utility, reexamine how each item is scored and calculated to revisit and assess the tool's objectivity.
- If it is determined the RAI does have remaining utility, conduct a current test of the tool as is, using appropriate outcomes. When possible analyses should also include tests using subgroups of the youth population (e.g., categories of ethnicity, sex).
- If possible, statistical analyses should consider the use of other standardized items that may display better predictive validity than one or more of the current items on the assessment.
- The appropriateness of the weighting and scoring of items should be examined.

#### *The RACF*

The development of the RACF had the specific objective of creating an instrument that could reliably predict the statistical likelihood a youth who had been released to a residential facility would return to a JR facility. Like the RAR and the RAI, many of the items on the RACF have at least face validity, and likewise the RACF contains a mix of dynamic and static factors. Not surprisingly the RACF takes into consideration within-community facility behavior (e.g., progress in the facility, problem solving skills, type of responsiveness, compliance with rules) and likewise utilizes criminal history items such as history of escape, prior commitments, offender type (sex offender), age at admission, and substance use/abuse. The RACF does utilize mental/behavioral health needs, and moreover utilizes prior mental health placements in the scoring strategy (two different items tapping the same domain). The same issues for the RACF emerge as those that presented themselves with the mental health item on the RAR female. Mental health needs are largely regarded as a responsivity issue as opposed to a risk factor or criminogenic need, making their inclusion in a risk assessment potentially problematic. In addition, the extent to which female youth are at least somewhat more likely to have a mental health diagnosis may also bias scoring in some instances (while system-involved males often go un- or under-

diagnosed). Of particular concern however, given the weight of the item (20 points – making it one of two of the most heavily weighted items on the instrument), administrative procedures make it possible for youth to be placed in a mental health unit due to space shortages as opposed to an active behavioral health need. As such their risk level may be artificially inflated which in turn has implications for the youth's experience and treatment in the community facility.

As a whole the RACF does have some face validity regarding some of the items that are captured, in particular those that are dynamic and relate directly to youths' behavior. These items may have some value as they relate to the measurement of in-program behavior and progress, but only if the items are utilized several times over the course of a youth's stay in the facility and were reconfigured for a different use. As it currently stands the Client Behavioral Assessment (hereafter CBA) may already fill the need for the measurement of in-program behavior and progress. The following recommendations are put forth should the RACF be considered for use going forward:

- Reconsider whether the CBA (with needed reconfiguration and/or revalidation work using the CBA) could fulfill the needs that are currently met by the RACF.
- If the RACF is retained, conduct a current test of its validity, including an item-by-item analysis, using appropriate outcomes. When possible analyses should also include tests using subgroups of the youth population (e.g., categories of ethnicity, sex).
- If data are available consider the inclusion of other standardized items that may display better predictive validity in exchange for items that may warrant replacement.
- The appropriate weighting and scoring of items should also be examined.

#### *The ITA*

The ITA is an in-depth and broad assessment protocol designed for use with system-involved youth. Approximately 10 criminogenic domains are assessed using over 150 unique items/questions that are populated through the use of a lengthy interview process with correctional professionals along with checks of official records. Each of the domains are assessed using both static (e.g., unchanging) and dynamic (changeable) metrics. The use of dynamic methods makes possible the measurement of change over time and via effective programming.

In addition to identifying the existence and magnitude of specific criminogenic needs, the ITA also offers a snapshot of what is termed “risk” and “protective” factors and levels. “Risk” in essence means that a particular domain exists in a manner that is conducive to the commission of delinquent behavior (in this sense, what is being identified is an area in need of intervention via effective treatment programming). “Protective” means that a particular domain has characteristics that are insulating a

youth from committing delinquent behavior. According to the ITA a particular domain can have both “risk” and “protective” factors, which makes possible the creation of comprehensive case planning that can drive treatment interventions. Take for example the domain of leisure or free time. A youth might have an excess of unstructured, unsupervised free time, which would be a “risky” situation that exposes the youth to opportunities conducive to delinquent activity. The youth could also have very specific prosocial interests, such as a specific sport, or an activity like model building, that could be capitalized on in order to occupy (previously) unstructured free time. The ITA rates all assessed domains on both “risk” factors and “protective” factors and does so using the classification labels “high,” “medium” or “low” rating, giving the end-user a concise summary of active criminogenic needs, as well as protective factors that could be capitalized on at some point.

When used appropriately, the ITA is an investment via time and expertise. It takes time and great attention to detail in order to conduct the necessary interview, verify information via official records, score all the items, and complete the summary assessment. The result is potentially worth the effort in light of the comprehensive nature of the information gathered, the depth of detail, and the form (dynamic) in which the information is gathered and used. As noted above, the ITA can be used for case planning, which ideally will detail the specific type of programming that is necessary in order to address active criminogenic needs. In addition, within the context of a valid case plan the ITA will reveal specific targets that should be met that will address the need, and depending on the severity of the need, the ITA should offer an idea as to what the appropriate length of treatment may be (although this lattermost point will require additional research and analysis in order to determine specific dosage recommendations).

In addition to an initial case plan the ITA also offers the potential for measuring change over time, which can inform both an individual youth’s progress via programming, but can also (with the right analyses) offer how effective a program might be in meeting a specific criminogenic need. Because of the dynamic nature of many of the items and domains, subsequent assessments can be compared to initial baseline scores in order to measure progress or to indicate the need for more intensive intervention of a longer duration. Currently the ITA is conducted toward the beginning of a youth’s JR stay and again toward the end, however, there may be value in conducting the ITA (or portions of it) more often, particularly for youth who are housed with JR for a lengthy period of time, who are likewise involved in specific rehabilitative interventions.

The JR system would benefit from the ITA having more universal recognition among all staff that work with youth in any capacity. One of the advantages of any comprehensive assessment is the

potential that it forms that basis for a common language with which to refer to the corrective and rehabilitative activities that youth participate in, in addition to language related to the criminogenic sources of antisocial behavior. While the ICI represents a shortened summary of the ITA, it would be beneficial for more staff – even those who are not “end users” of the actual assessment itself – to have more knowledge of the ITA, how it is done, the methods by which the information that goes into the assessment is rendered and of course the information itself. Increasing the “profile” of the ITA throughout the JR system will allow for better implementation of the Risk, Need, and to some extent the Responsivity principles of effective correctional intervention. To that end, fuller utilization of the ITA’s potential will allow for the aforementioned case planning and the identification of behavioral targets, and likewise it can be used to inform risk/need classification systems (e.g., high, medium, low) and in turn inform housing decisions, treatment referrals, time served decisions, and readiness to engage in or emerge from treatment opportunities. In light of the comprehensive nature of the ITA, the resource investment, and the assessment’s potential the following recommendations are put forth:

- The ITA should serve as the flagship assessment for the JR, and should form the basis of a number of functions and likewise inform a number of decisions including but not limited to:
  - The building of a comprehensive case plan that identifies the most pressing criminogenic needs (targets for treatment), and that also utilizes protective factors. The case plan should serve as a living document that guides a youth’s trajectory through JR including treatment referrals, mechanisms where by targets for change will be met, and benchmarks that reveal progress.
  - The risk/need classification system should be used to make housing decisions, insuring that youth with similar levels of risk/need and similar criminogenic targets are housed together as much as is possible. The classification and housing decisions may also include staffing levels where possible (e.g., a higher risk group would have more staff present, a lower risk group may possibly have fewer staff).
  - The ITA should be used to measure change whenever possible. Change over time may require additional administrations of the ITA (either in full or specific portions). Evidence of change via rehabilitative intervention should be used to make changes to the case plan as well as placement and release decisions.
- The ITA and the concepts that serve as its foundation should be used to inform all staff that deal with youth to any degree. As noted above, a good comprehensive risk/need assessment can offer a common vocabulary and a common purpose and foundation to a rehabilitative system.

- Plans for a test of the ITA's predictive validity should be made and implemented. The ITA may have utility in predicting the statistical likelihood of any number of outcomes, including but not limited to within-facility infraction, return to a facility (after placement in a community facility), and post-release recidivism.
- The data that are rendered from the ITA should be used to drive needed treatment programming. For example, it is possible that the JR does not currently have the capacity to address one or more criminogenic needs of the youth in light of prevalence within the population.

**Questions 2: Are youth being appropriately matched with treatment based on assessed risk and need?**

The ITA is not currently driving the treatment model to the extent that it could. Best practices in correctional intervention specify that a comprehensive risk/need assessment should drive any rehabilitative treatment model whereby youth are matched to the appropriate treatment based on the results of the assessment. Too often (nationally) youth are offered treatment activities that appear appropriate in general, but the treatment is not specific to the needs of the youth. In short, systems often offer clients the services that are available regardless of the need profiles of the individual. Ideally an assessment like the ITA is used to identify the unique risk/need (including the active domains) for each youth, and the youth is in turn referred only to services that are specific to the needs that are revealed. As it currently stands, youths' treatment activities are driven by their housing placement, which in turn is driven by psychological assessment. When validated assessment activities and information are utilized to make treatment-related placement decisions, youth are more likely to receive only the services they need saving costs in the long term by avoiding wasted services. Related, risk/need assessment information may reveal the need to increase treatment capacity specific to one or more criminogenic needs. "One-size-fits-all" treatment portfolios not only run the risk of wasting scarce resources on youth who are not likely to benefit from them, but there is evidence that over-programming youth (i.e., delivering unneeded services) may actually make youth more likely to recidivate via a violation of the risk and/or need principles.

Another aspect of matching involves the rehabilitative principle of responsivity. The principle of responsivity requires that correctional systems take into account characteristics of the individual that may serve as barriers to successful placement (such as a housing placement) or barriers to successful engagement in treatment activities. Responsivity characteristics can come in a variety of different forms, and are by definition specific to the individual youth, however many of them can be placed into broad categories that agencies can consider in the aggregate. By taking responsivity considerations into

account an agency can better insure that youth placed in specific treatment activities will benefit as anticipated. In addition to placement decisions (housing, treatment) responsivity factors can also be used to match youth with appropriate groups, as well as youth with individual staff such as correctional counselors.

Some of the most useful responsivity considerations include personality type (e.g., Myers Briggs typologies), IQ, motivation to change or readiness to engage in treatment, reading comprehension, maturity, as well as demographic factors. As a basic example, consider treatment curricula such as cognitive behavioral treatment materials, which are often written at a specific reading level. If a treatment program or agency does not assess reading comprehension, there is a risk that some of the youth placed in a group using the curricula will not benefit in the intended manner due to an inability to comprehend. A more complex example might involve motivation to change or readiness to engage in treatment. Youth often present varying levels of readiness to change their behavior. A lack of motivation to engage may come from a variety of sources, but is often due to a failure to recognize that the lifestyle is leading to delinquent behavior, attention from law enforcement and corrections, and in turn a loss of liberty and pro-social opportunity. When a treatment program or agency intentionally and formally assesses motivation to change behavior, it is possible to make better placement decisions, and likewise streamline scarce resources. For example, if a group of youth are highly motivated to engage in treatment activities and work toward changing their behavior, they are good candidates to engage in need-specific programming right away. If on the other hand a group of youth are assessed as not being motivated at all (and are often quite the opposite, and are prone to creating disruption if placed in treatment activities prematurely) it might be more appropriate to work with them on their motivation first, before engaging them in specific treatment activities that are focused on a specific criminogenic need.

In order to make decisions based on responsivity factors, an agency must assess one or more responsivity domains. The assessment of responsivity is typically domain-specific and is done via a specific assessment. For example the aforementioned personality typing can be done via Myers Briggs testing or motivation can be assessed via the Socrates stages of change process. It is generally recommended that agency stakeholders determine what responsivity factors are most relevant to the population being served and choose a method of assessment(s) accordingly. In the meantime the agency may benefit from merely increasing awareness of responsivity and how it impacts treatment effectiveness. It is very likely that responsivity concerns are revealed via the ITA interview process, and likewise during various other assessment procedures including one-on-one time with agency

psychologists. As such, awareness of responsivity and the incorporation of relevant information in decision making is paramount.

**Question 3: Does the current quality assurance plan adequately monitor assessment performance?**

Quality assurance activities are in place but there is some room for improvement pending the availability of additional resources. Interviews revealed that staff who are designated to conduct the ITA assessments go through a rigorous training led by a seasoned master trainer who has an immense amount of experience using the ITA, as well as experience in relevant training activities. Intensive and high-quality training is typically the first part of a quality assurance plan for any comprehensive and dynamic standardized risk/need assessment tool. Training should include foundational knowledge (e.g., the principles of effective intervention, with a focus on the Risk, Need and Responsivity principles and how those principles are implemented via high quality assessment activities). Training should also include activities that facilitate expertise in the use of the tool, and should go over each item and how each item is scored, and how each scored item gets added to a domain's score as risk or protective. Scoring should include scaling (low, medium, high) for each domain as well as overall classification.

Foundational training, like most learning experiences, should be active and experiential, involving numerous realistic and “hands on” examples that require the utilization of newly acquired skills. Foundational training should also include at least some initial tests of inter-rater agreement in order to insure that all trainees are viewing the same situations similarly and are likewise scoring items in a similar manner. Also helpful is the inclusion of training on good interviewing skills, though it is recommended that motivational interviewing not be used during ITA assessments. Motivational interviewing consists of a defined set of skills and techniques that were designed for assisting the interview subject to identify cognitive thinking errors related to their functionality (or lack thereof) and other ways in which they might not be living an ideal prosocial life. Motivational interviewing may be a useful technique as a pre-treatment intervention (meaning before a youth engages in cognitive behavioral group therapy, for example) or as an intervention in and of itself. For the purposes of assessment however, the interviewer should make efforts to assess each item and domain as they exist currently and in reality. Using motivational interviewing within the context of an objective and standardized assessment process might cause the subject to modify their answers if they sense that they are offering the “wrong” answer, for example.

After successfully emerging from initial foundational training, trainees should be afforded a period of time during which they can practice using the assessment procedures and conduct scoring in a real-world setting, but without influencing interventions for the youth. Audits should occur of these

initial practice assessments in order to best insure quality procedures and scoring. As efforts are created to insure proficiency, processes should be put in place that indicate when a staff member is ready to conduct assessments on their own.

Once staff have been approved to conduct assessments independently several procedures related to quality assurance should be developed. These procedures should include the following, tailored to fit the unique needs of JR:

- Regular tests of inter-rater agreement, and plans for regular tests of inter-rater reliability.
- Booster sessions on a regular schedule such as an annual conference. Booster sessions would be for individuals who successfully completed an initial/foundational training, and would focus on some aspect germane to the assessment process (e.g., scoring, reliability, foundational principles and vocabulary, case planning, the measurement of change).
- Quality assurance should include one-on-one observation where a master trainer observes a trained staff member conducting a complete assessment, while also conducting their own scoring of the individual being assessed. This will serve as an opportunity to offer feedback on interviewing skills, overall proficiency, scoring issues, and could also serve as at least a cursory test of inter-rater agreement.
- The ITA should be subject to regularly occurring tests of predictive validity (e.g., every 3 to 5 years, depending on changes in agency mission, the population of youth, or legislative developments that might influence case processing and/or JR resources).

As noted above, the RAR, RAI, and RACF consist largely of static criminal history items many of which are scored automatically from existing data. The same quality assurance efforts should be put forth for the items that are not scored automatically and those that are not static in nature. Efforts should be made to insure that staff conducting assessments are measuring dynamic items the same way, and that there is an acceptable level of interrater agreement. Similarly, efforts should be made to standardize potentially subjective information that is currently used to score items. Specifically the Client Behavioral Assessment, or CBA as noted above, is a practitioner-driven process that rates the youth regarding their behavior. Using real-time/current observational and behavioral-based information to score risk/need assessments is potentially very valuable, but also holds the potential to enter subjectivity and bias into scoring. As such it is of paramount concern that extensive training and definition is afforded to those conducting a CBA. It should also be noted that the CBA may have additional utility beyond informing the assessments, such as the measurement of change over time, determining when behavioral benchmarks are met, and informing the overall case plan. As noted above,

quality assurance efforts as they relate to the RAR, RAI, and RACF should involve regularly scheduled and large-scale tests of predictive validity using appropriate outcomes, exploring alternative outcomes, sub-populations of the youth (e.g., by race, ethnicity and sex), and should likewise include test for bias.

**Question 4: What recommendations do you have to improve the assessment system in JR, given the current level of resources?**

Three overarching recommendations emerge regarding the current assessment system in JR, related to four of the assessments currently in use. These recommendations are geared toward positioning JR to utilize existing assessments to their fullest, in an effort toward more complete implementation of the Risk, Need, and Responsivity principles of effective intervention.

If the RAR, RAI, and RACF will continue to be used, their use should be limited to other parts of the justice system (meaning other than driving a treatment model). Currently these three assessments are not fully integrated into the treatment model, nor do they possess characteristics that would facilitate a treatment model. These limitations are due in large part to their make-up. The assessments are largely made up of static criminal history items, with some dynamic items that may cover a criminogenic need, but not to the extent that would be necessary to drive case planning and/or intervention. The assessments may have some utility in other areas of the system (meaning other than treatment), pending the results of predictive validity tests. As such, their continued use should be based in large part on both the results of tests of predictive validity as well as the overall agency objectives.

Related to the recommendation immediately above, plans should be made for a large-scale and current test of predictive validity for all three assessments (RAR, RAI, RACF) using relevant outcomes. Under the assumption test results will reveal acceptable levels of predictive validity, these instruments should be used for more justice-related (as opposed to treatment-related) decision making. For example, the risk assessments might have utility when making decisions about the appropriate level (intensity) of community supervision, the appropriate level of residential placement, and other case processing decisions related to security (e.g., curfew recommendations, electronic monitoring and the like).

It is recommended that priority is given to the ITA when it comes to driving the treatment model currently in place. Of the assessments reviewed the ITA has the greatest potential to contribute to case planning, the identification of relevant criminogenic targets, the measurement of change, the overall risk/need classification model, and support/evidence when it comes to any number of case processing decisions as they relate to a youth's treatment trajectory. In order to meet the ITA's full potential it is recommended that the instrument is more fully understood across all individuals in the JR system

(particularly those that have any contact with youth, abiding by the understanding that any person that has contact with a youth can have a role in helping to shape behavior). While the ICI provides an overview and summary of the information provided by the ITA, there is benefit to a fuller understanding and systemic penetration of the ITA, the information it gathers, and the ways it can be used in order to best implement the principles of risk, need and responsivity (though as noted above the ITA may only contribute to the assessment of responsivity indirectly).

**Question 5: What additional resources would you recommend to improve the assessment system and integration?**

While it is not possible to attach a specific dollar amount in terms of actual additional resources, the JR's assessment system would stand to benefit from one or more of the following recommendations. For example, plans should be made to develop a point person who would be responsible for all activities and procedures related to assessment within the agency, for example, a "Director of Assessment." The Director of Assessment would likely need at least a small administrative structure (staff) that would be dedicated solely to implementing, monitoring, and driving everything related to the system's assessment procedures. The new administrative position would oversee new and ongoing training for existing (and newly adopted) assessments. The position would also be responsible for conducting quality assurance reviews of case plans derived from assessment activities insuring that they are driven by the RNR (Risk Need and Responsivity) principles. Likewise, the position would oversee regularly scheduled tests of validity for all assessments in use, as well as efforts to insure acceptable levels of interrater agreement and interrater reliability, and would also oversee the adoption and implementation of a standardized responsivity assessment process. Under the assumption that assessment activities should drive, and be integrated with the treatment models, the Director of Assessment would be ultimately responsible for making sure that true integration occurs. Assessment procedures are the cornerstone of any effective intervention model, and as such the integrity of the information that is gathered, the way the information is used, and the extent to which the information undergirds every part of the system is paramount.

Additional resources would also benefit the expansion of treatment and rehabilitative activities within the JR system. As noted above, if additional focus is afforded the ITA, it is likely that gaps in the current treatment model will be revealed. These gaps will likely show a need for additional capacity in treatment services that can address criminogenic needs in a variety of ways. In addition to revealing the need for additional services – meaning both type and capacity (e.g., expanded rehabilitative offerings such as cognitive behavioral interventions focused on substance use, relationship building, views of

work or school), effective treatment models also are able to vary the intensity and duration of the intervention depending on the severity of the criminogenic need. For example, information from the ITA may reveal that two youth may require that the same criminogenic need be addressed, but they each might need a different amount of programming in terms of intensity and/or duration. In order to allow the ITA to drive treatment fully, programming will need to have as much flexibility as possible when implementing case plans and addressing treatment targets.

Additional resources should also be allocated for testing and monitoring the integrity and quality of all treatment programming. While this particular recommendation may initially appear to be outside of the purview of assessment, credible efforts to assess program quality take the assessment model heavily into consideration. Commonly used procedures that quantitatively assess the quality of rehabilitative programming will determine whether or not valid assessment procedures are in place, how assessment information is gathered and used, and to what extent the assessment information is being used to the fullest in driving programming and monitoring both individual progress and program effectiveness. In addition program treatment audits consider whether all three principles of risk, need, and responsivity are appropriately implemented and are present in every part of the treatment program. Resources that are dedicated to program evaluation should be part of a comprehensive assessment model.

**Question 6: JR will be serving youth up to age 25 in the future. What advice related to the assessment system would you give the agency as they prepare to provide this treatment for older youth?**

It will very likely be necessary to adopt, implement, and test the validity of a tool designed to assess the adult offender population. Most if not all of the recommendations mentioned above also apply to any adult-based assessment model as well. When comparing the youthful offender population to the adult offender population, there is a great deal of overlap regarding the criminogenic needs that contribute to an increase in the likelihood that antisocial behavior will occur. However, the form of the criminogenic needs will vary, and as such the measurement tools that are used should vary as well. Youth for example are more likely to have parental figures as active parts of their lives that in turn contribute to the constellation of influences the youth is surrounded by. At the same time, youth are less likely to have dependents to consider. Young adults 18 and older are less likely to be influenced by parental figures and more likely to have specific factors in need of consideration, such as dependents. In addition, any number of status offenses (the use of alcohol and in some states marijuana, for example) provides a potentially large degree of difference between youth and adults, and assessment models should reflect the difference. Tools such as the LSI-R, the COMPAS, the ORAS, or another comprehensive

tool of sufficient breadth and depth that has a high degree of demonstrated predictive validity should be considered for the young adult population JR will be serving more of in the future. Once adopted, best practices in offender assessment as they relate to training, implementation, and tests of validity on the local population should be observed just as those principles that have been recommended above.

It is possible that portions of the ITA could be used on the young adult offender population, but it would be necessary to go to great lengths to ensure that the tool (and/or the portions therein) do indeed adequately predict the desired outcomes for young adult offenders aged 18 to 25.

**Appendix D:** Implementation Assessment of Dialectical Behavior Therapy  
by Dr. Linda A. Dimeff

## **Washington State Juvenile Rehabilitation Report**

### **Dialectical Behavior Therapy**

**Report by:**  
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**Submitted:**  
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## Executive Summary

Washington state Juvenile Rehabilitation (JR) has long been on the forefront of developing and implementing Dialectical Behavior Therapy (DBT) – an effort it initially commenced nearly 25 years ago. JR has sought to implement DBT to fidelity – across modes and functions. The intention of this review was to determine the extent to which DBT is provided at JR and to make recommendations as needed. To make this determination, several JR site visits were made during November, 2019. Whenever possible, visits included conversation with a range of staff (leadership and frontline youth counselors), visiting the units, and speaking with youth.

### Key Findings:

1. The intention to provide DBT to fidelity is deeply rooted – from the behaviorally specific DBT standards for each DBT mode to the sophisticated and rich intranet of DBT resources to aid in its delivery. Beautifully produced DBT skills training posters line the walls of the units – in plain sight for all (youth and counselor) to see/use. When randomly asked, youth are generally able to name and describe one or more DBT skills they use.
2. Staff shortages and staff turn-over have significantly compromised JR's ability to train up its workforce in DBT and to maintain whatever training gains it makes. Non-competitive wages make it particularly challenging to recruit personnel at all levels (AA, BA, MA, PhD). The situation is even more dire in rural areas.
3. Training, consultation, and supervision resources are insufficient to meet the actual demand that counselors have in order to fulfill the DBT standards and deliver DBT to fidelity. In contrast to the early years of DBT implementation at JR where staff attended intensive trainings with ample consultation from other JR DBT experts, the trainings are now limited to two and three-day trainings and very limited consultation by three DBT consultants who span all of Washington state. Staff shortages have made it difficult for new staff to attend the trainings that are offered.
4. The trainings that are offered are dense in what they seek to cover, include numerous slides. It is hard to see how these standard trainings by themselves are sufficient to produce behavior change in counselors (let alone adherence to DBT) if not paired with ongoing consultation, support, evaluation of their actual performance (recording of sessions for review by experts, real-time observations of sessions), opportunities to truly practice and gain feedback, and deep engagement with reading/studying other materials. The degree of training made available to the original cohort in the late 1990's was vastly different from what is made available today. This early cohort participated in a two-part 10-day intensive training that included reading multiple DBT and other treatment manuals + completing a DBT exam (open and closed book) + case presentation + program presentation in front of other teams compared to attending traditional didactic workshops. The initial group received training directly from DBT treatment developer, Marsha M. Linehan, PhD; I co-taught with Dr. Linehan at this initial training. Indeed, the Copalis Cottage Treatment Manual was a product of that training. (For what it is worth, there is very little evidence to support the efficacy of traditional training workshops to promote behavior change in clinical practice).
5. The Environmental Adherence (EA) function of DBT has deep roots throughout facilities. The DBT standards accurately capture what a gold-standard JR system should seek to do. The DBT Skill of the Week, with rich content available through the JR intranet and in a weekly email

makes it (in theory) easy to access rich, adherent training and help ensure the teaching of and coaching in DBT skills. It appears that most units fulfill the DBT Skills Training standard of providing this mode to youth. Fulfilling the standard for DBT consultation team and didactics varies significantly by unit and facility. Even in cases where a consultation team meets, it is unlikely that the function of this important mode is achieved as members don't know DBT. With respect to the individual delivery of DBT, with the exception of a handful of old-timers who received comprehensive training and consultation in DBT, the majority of today's counselors have not have enough training to know how to deliver DBT individual counseling to fidelity. Barriers to recording sessions make it impossible to know, but most interviewed felt confident that what goes on behind the closed door resembles garden-variety counseling.

6. Staff are divided over whether it is realistic and necessary to offer comprehensive DBT to all JR involved youth and whether it is realistic to expect AA/BA level counselors to provide DBT individual counseling to fidelity. We know that it is possible for AA/BA level counselors to deliver DBT to fidelity *when they are provided* the kind of training, supervision, and consultation support that is required initially and over a period of time until fidelity (based on review of tapes) is achieved.<sup>1</sup>

### Recommendations

1. **Reduce Staff Shortage and Improve Retention.** It is difficult to see how to improve system-wide fidelity to DBT unless there are enough staff to provide coverage while others attend trainings, and that staff stick around after the training investment has been made.
2. **Reconsider Comprehensive DBT for Some (vs. Comprehensive DBT for All).** It is a noble effort to seek to provide comprehensive DBT for all youth, particularly in light of the real challenges to hiring and retention of staff. While DBT for All may be the ideal, it may also not be affordable (and therefore realistic). It is better to provide comprehensive DBT well to those who need it the most rather DBT Lite for all. Clear criteria could easily be established to determine those who most need DBT counseling to fidelity. A small cohort of clinicians/counselors could then be trained and supervised to ensure they have the capability of providing DBT to fidelity in the individual counseling mode. All other residents could receive DBT Lite (EI, DBT skills). Those selected to provide 1:1 DBT to fidelity may also have additional incentives to tackle work with the most difficult of youth (e.g., more training opportunities, opportunity for more competitive wages, protected time for consultation team).
3. **Offer Comprehensive, Intensive Training in DBT over a Year.** I would strongly recommend that Washington State JR resumes its former practice in sending those counselors that it wishes to provide DBT individual counseling to a five-day DBT foundational or 10-day intensive offered by a reputable organization, like Behavioral Tech or Portland DBT Institute, Inc. The intensive should include not only didactic and role play instruction, but also a DBT exam (open, closed book), a requirement to read relevant textbooks (or the Copalis Cottage manual that was developed in the late 1990's), individual and team assignments, including presentation of a case

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<sup>1</sup> One study by Linehan and colleagues found that it took a PhD level well-trained behavior therapist two years to achieve DBT adherence in the individual therapy mode of treatment. This was among a sample of clinicians who also attended the DBT intensive and had weekly supervision that included tape review. In my experience, this process can go faster if the clinician is embedded within an organization that is steeped in the practice of DBT. For example, at Portland DBT Institute, Inc., it takes approximately 12 to 18 months until a licensed clinician is fully adherent in this mode. These clinicians also attend an intensive training, complete all its requirements, and submit audio recordings for adherence review.

and program to other attendees for feedback. The requirement to share out your work has a contingency management function, where people are motivated to do well knowing they will need to describe a case/program in front of their peers. In some systems, the five days are divided into a set of 3 days (Week 1) and 2 days (Week 2) to reduce the burden in covering work for line staff. The existing trainings can augment, but not replace, this comprehensive training.

4. **Expand the Number of DBT Experts to Provide Support.** It appears that the three consultants are insufficient to provide the needed coverage to all counselors and program managers throughout the JR system. Also, it would be wise that the consultants are also themselves DBT experts. One way to ensure that this is the case is by selecting individuals who are Linehan-DBT Certified as clinicians. If JR is unable to hire more, it might consider developing a relationship with other DBT experts with deep JR experience – either through Behavioral Tech, LLC or Portland DBT Institute, Inc. or other comparable group.
5. **Encourage/Require Audio Recording of Individual Counseling Sessions for Review and Feedback.** To help counselors learn DBT and to guard against drift, it is important that individual counselors record their sessions. These sessions can be reviewed by their supervisors and consultant to monitor delivery of treatment and reviewed in consultation team for purposes of receiving help.

## BACKGROUND

**History of DBT in Washington State Juvenile Rehabilitation (JR).** Washington State JR began its application and implementation of Dialectical Behavior Therapy (DBT) in 1998 when it first began developing an innovative adaptation of DBT for its youth in facilities. This highly ambitious adaptation was initially developed in a single cottage (Copalis Cottage) on one campus (Echo Glen Children's Center) that served females with mental health problems who also engaged in suicidal and non-suicidal self-injurious behaviors. These early adaptations described in the Copalis Cottage manual – a sophisticated translation of Linehan's early treatment manual for Washington State JR staff at all levels.

As the data from this early work yielded positive findings, DBT was expanded throughout Echo Glen and all JR facilities and for the youth it served. During this “golden period”, significant and extensive resources were devoted to expert training and consultation in DBT. Indeed, Linehan and/or her protégés (Kelly Koerner, PhD, Henry Schmidt, PhD) were among those who provided extensive training and consultation to JR over the years. Interviews with staff who recall these early years describe extraordinary training/consultation resources: experts listened in on sessions, attended consultation teams, and were available for clinical review of complex cases. Low rates of staff turn-over made it possible for staff at all levels to routinely attend regular trainings and for these efforts to find their way into clinical practice.

One particularly innovative JR adaptation established early involved delivery of the individual therapy mode of DBT. Linehan's standard outpatient model involved use of masters level and doctoral level licensed clinicians to administer individual therapy. The JR model instead relied on unlicensed frontline staff with two to four-year college degrees to provide this mode. It rightly reasoned that frontline staff have the greatest contact with youth and the capacity to significantly and positively influence (behaviorally shape) the youth's behavior through their contact with youth in the milieu. Presumably, it became a cost-efficient way to provide the individual counseling mode, as frontline staff were already tasked with meeting with youth on a routine basis multiple times a week. The high degree of training, consultation, and supervision, in combination with the system's overall investment in DBT implementation, made it possible to provide the requisite training to individuals not formally trained as clinicians. One benefit of this approach was that DBT principles, strategies and philosophy could be woven into the youths' care from the time they woke in the morning to the time they went to bed. For example, youth in Copalis began their day with mindfulness, goals setting, and DBT skills they could use to achieve their daily goals. To ensure DBT was as much of a voluntary choice as possible, counselors would give youth the choice of whether to participate in the morning group. Those who opted to participate were first in line for breakfast (contingency management strategy).

Within a decade of its initial effort, Washington state's JR DBT adaptation became the gold-standard for other similar facilities. Indeed, the “Echo Glen” model was disseminated to other juvenile justice facilities throughout the United States and other parts of the world. Its “home-grown” DBT experts (those who were at its inception), including Dr. Schmidt, Brad Beach, Ron Baltrusus, grew over time a robust in-house training team. Under the stewardship of Ted Ryle and his colleagues, JR has developed a top-notch set of DBT training materials and processes that is the envy of other large system implementations and other professional DBT training organizations. These sophisticated training and clinical materials remain readily available to all JR staff via their well-developed intranet.

**Findings from An Evaluation of Dialectical Behavior Therapy in Washington State's Juvenile Rehabilitation (2019).** While numerous studies had been conducted on its outcomes, no formal

processes had been implemented to measure the quality or adherence of individual counseling sessions, skills groups, or consultation team from 2000 to 2019. Quality Assurance (QA) protocol only monitored environmental adherence (EA; one of four DBT treatment modes known as “structuring the environment” to enable delivery of DBT throughout the treatment environment). The results of this undertaking are summarized in this [2019 report](#). Key findings detailed in the report include:

- In 2014 and 2015, about 57% of youth who left JR did not receive the level of treatment required by at least one of the three separate standards (EA, individual sessions, and skills groups)
- About 21% of youth received treatment that met one standard, 18% received treatment that met two standards. Only 4% of youth left JR having received treatment that met all three standards.
- Increases in EA were associated with reductions in felony recidivism.
- Rates of individual sessions and skills group were not related to recidivism, however, the quality of those sessions varied widely and was not systematically assessed.
- High levels of EA were particularly important for younger youth and those with a high risk of mental health issues.

On the basis of these findings, recommendations included:

- To begin monitoring individual session, skills training and consultation teams
- JR should prioritize high-level implementation in the acute mental health units. Training and staff resources should be dedicated to these units to bring them up to standard as quickly as possible.

## ASSESSMENT

**Materials Review.** In advance of visits and interviews at facilities, I was provided ample examples from the JR Home Page/SharePoint as well as the PowerPoint curricula for three DBT trainings. (Please see Attachment A for a summary and review of these materials). Washington State JR has provided its counselors with comprehensive, DBT adherent materials to enable the standardized delivery of DBT skills through its impressive Skill of the Week materials. This includes a weekly email, a carefully constructed indexing of skills, easy to access documents to support training that are relevant to their population. Anyone with access to these materials can easily download a full teaching curriculum for DBT skills training with minimum effort. The two-day workshop materials are both adherent and exhaustive in their review of DBT. (Indeed, my only concern is that there is too much content to deliver in two days, particularly if demonstration and role plays are involved. No doubt JR trainers have considered this and know how best to tailor the content to their audience).

## OBSERVATION

**Green Hill School (GHS).** I visited GHS on two occasions: November 8, 2019 and November 12, 2019. The primary purpose of the second visit was to visit the units and speak directly with as many line staff and youth, as possible. On both visits, staff spoke candidly about their experiences at GHS. It was clear that staff cared about their work, helping their youth, and supporting each other. It was immediately

apparent to me that all staff had a shared behavioral (DBT) framework for their work. Notable comments included:

- Concern that the size of the three larger units (Maple, Spruce, and Hawthorn) make it difficult for staff to provide the expected level of therapeutic intervention. If one youth is on an observation level (comparable to a one-on-one in an inpatient hospital setting) as part of the system's suicide prevention procedure, for example, it is very difficult to leave the floor to have a counseling session with another youth. The same number of staff are assigned to the large units as to the small units. Those staff with 40 youth per unit have "no time to deal with things that arise in the moment".
- **Staff Shortages, Staff Hiring and Staff Turn-Over Challenges.** Staff turn-over is high with an annual staff turn-over rate of approximately 30%. Most staff are in their first two years of employment and lack training. When asked about the high rate of turn-over, the supervisor I spoke with noted that the Washington State JR salaries are no longer competitive; Big Box stores, like Walmart, pay comparable salaries and offer comparable benefits for a much less stressful job. He stated while hiring has improved, the incentives to retain staff (salary and benefits) are not competitive, which is likely then to further perpetuate the problem even if hiring efforts are improved.
- **Insufficient Resources to Train New Staff.** Because of the shortages, there is simply insufficient coverage to allow new (and less new) staff to receive training in DBT. I met with one supervisor who shared with me his log of trainings attended by his staff: most of the newer staff (and some of the less new staff) had not attended basic DBT trainings. He simply could not free them up enough to attend the required training. Staff shortages and limited "off the floor" time also mean that counselors do not have time to use the JR Homepage to augment their training.

The most well-trained employees work on the day shifts while the youth are in school. The newest and least trained staff work the swing shift and while they are doing their best, they are more likely to end up reinforcing dysfunctional behavior.

- **Staff Shortages Compromise Delivery of DBT.** Staff shortages also make it difficult to make time to provide weekly counseling sessions. In theory, each counselor is assigned between two and six youth to meet with during their day they are scheduled to be "off the floor". Seldom are there sufficient staff available to allow counselors to have their scheduled "off the floor" shift. There was a general belief among those I spoke with that while JR says DBT is important, there is little investment of resources to make successful implementation possible. There simply are not enough staff to provide coverage for all shifts to allow new employees to attend trainings. The trainings that receive highest priority are those required to onboard new employees to safety procedures. For example, a 40-hour course in defensive tactics is required by all new hires. While DBT courses are available, they are lower in priority because of staffing shortages.

It is estimated that only 20% (max) of counselors attend consultation team. Among staff I spoke with, some did not know that consultation teams were provided. Many are simply unable to leave the floor due to staff shortages to attend a DBT team meeting.

**Variability in Quality of Care.** Youth assigned to counselors who have been in JR for many years have a fundamentally different experience and care than those who are within their first five years at GHS because of the staff shortages and limited ability to take part in training. Many counselors are unable to get off the floor to provide individual counseling sessions with their youth. When speaking with supervisors and managers about the quality of individual therapy,

the majority of those I spoke with indicated that they have little reason to believe that youth are receiving DBT counseling during their 1:1 appointments because they are insufficiently trained. When asked what treatment was provided, those I interviewed suggested it was most likely garden-variety counseling that they learned during their undergraduate college training. Because sessions are neither recorded or observed, it is impossible to actually know what occurs. With respect to delivery of DBT skills training groups, many counselors simply lack the ability and training to know how to conduct the DBT skills training group. While there is a commitment (DBT standard) to have all youth attend a DBT skills training session per week, it does not reliably occur.

One supervisor I interviewed described a very elaborate token economy he implemented on his unit. After some discussion of its merits and the system's willingness to provide him money to purchase items his youth would work for, he acknowledged that it was inconsistently used because his staff were not sufficiently trained in behavioral principles to use it well, and that staff shortages also interfered with consistent delivery of tokens and rewards.

- **Professionally Developed Posters.** The units are lined with professionally produced posters of the DBT skills at a height that makes it difficult/impossible to get torn down.

**Naselle Youth Camp.** I visited Naselle on November 25, 2019 for approximately four hours, during which time I had an opportunity to speak to its leadership team, youth counselors, view its school and several of its units. I was unable to speak directly with any youth because the hours of my visit coincided with their school day. The staff were generous in their time meeting with me and in their candor. As was the case at GHS, it was abundantly clear that those I spoke with were passionate about their jobs, serving their youth, and providing the highest quality clinical care. Notable highlights from the conversation included:

- **Staff Hiring and Retention Challenges.** Because of Naselle's location, it is far more difficult for them to hire as the pool of available applicants is small. Average non-competitive salaries further complicate hiring and retention of staff. Those that have stayed on for decades often have a corrections mindset with old biases that are inconsistent with JR's current treatment-focused approach. Many who were initially trained during the "golden years" have left. They highlighted that their staff psychologist position, for example, has been open for some time, further leading them to depend on the already stretched too thin JR DBT Consultants.
- **Insufficient Resources to Train New Staff.** Similar to feedback from GHS personnel, those I interviewed at Naselle stated that there is significantly fewer training, consultation, and supervision resources available to them now compared to two decades ago when DBT was rolling out. Resources included: greater available time to train and having easy to access DBT consultants who would come into join consultation team to help develop a case conceptualization for a particularly difficult youth.

During a meeting with program managers, one individual indicated that while new staff are supposed to complete a three-day DBT training early in their employment, most of their staff had been unable to attend the training but instead learn as best they can by watching peers or through self-study.

A number of staff pointed out that the DBT consultants do a fine job, but they are spread too

thin to be of real, enduring benefit. "When (consultant) is here, (they) does a great job helping us with a difficult kid. But she is stretched thin."

- **Youth are More Complex.** Youth who are coming into JR facilities are far more complex than they were even several years ago and trending to become more complex still. This speaks volumes to the importance of doing DBT well.
- **Variability in Quality of Care.** There is a significant disparity in care received by youth working with a more senior counselor and those assigned to a "rookie". The expectation that youth will receive DBT from Day 1 is unrealistic because new staff are not trained and getting them trained up in light of staff shortages that prevent them from attending trainings further complicate matters.
- **"DBT Lite at Best".** Because of staff shortages and significant reductions in training, supervision, consultation support to DO DBT, the overall consensus was that youth throughout the facility all receive some DBT, but that it is "DBT Lite" – consisting of "rudimentary BCAs and maybe a skill or two to help the youth". Naselle relies on a lot of "blocking" – structuring up the environment as a whole to limit/prevent dysfunctional behavior versus personalized youth-centered treatment plans.
- **No Quality Control over Counseling Session.** Leadership acknowledged that they have little idea what occurs in individual therapy sessions because of the lack of tape review. Some of this is due to a perception that unions will push back on JR requiring counselors to record their sessions.
- **Problematic Nature of Counseling + Corrections Mode.** Several questioned the original wisdom of the decision to have AA and BA-level counselors deliver the therapy – both because they lack the formal training and because of the incompatible roles they play with the same youth in terms of what is required while on the floor vs. in a therapy session. Essentially, there is a dual role between being security guard and clinician.
- **Who Needs Therapy? Who is Qualified to be a Counselor?** There was considerable conversation about whether every youth needed a highly specialized DBT clinician and/or comprehensive DBT. In their view, about 75% of the patient population will be positively impacted by the therapeutic environment alone: having established structure, routines, consistent use of rules, rewards, punishments. However, there is another 25% of youth who have severe and complex problems and require more than the therapeutic milieu. These youth, in their view, are best served by having comprehensive DBT delivered to fidelity and by a qualified (and licensed) clinicians. Their view was rather than trying to make comprehensive DBT available to all (since it is not possible given the resources), focus DBT on only those who need it the most – consistent with the original roll out of DBT at Echo Glen. In this model, develop specific criteria for those youth who need comprehensive DBT. One person recommended that there may still be a role for the youth counselor, but more as a case manager than thinking they are providing 1:1 individual therapy.

In recounting the decisions that led to the comprehensive system-wide roll out of DBT and 1:1 therapy provided by a BA/AA-level youth counselor, some staff recalled it being a point of contention from the start.

- **Coaching on the Floor:** They estimate that between 50% to 85% of their staff know how to coach a youth "on the floor".

- **Consultation Team:** “We have a if you are drowning, we can help” approach now versus a planful approach. System tries to ensure that its counselors receive weekly consultation team. The first hour is devoted to consultation; the second to administrative issues. Staff use a paper outline for team that has been handed down over the years. It does not include didactic training during this time. Team is also compromised by radios, need for 911 response to problems.
- **Skills Training Groups:** Occur weekly for youth, but often have 14 youth in a group at a time. (Difficult to engage youth with this size).
- **Overall Exposure to DBT:** Described as sporadic. Leadership estimates that only about 25% of youth receive the DBT model, as intended by JR. “We do really good at presenting on paper what we do, but it doesn’t match what we actually do”.

**Touchstone.** I met CF administrators. Both highlighted that when DBT first began, there was “tons of support for the (DBT) model – all the way to the top.” Yolanda recalled the transition from a punishment model (in the 1990s) to use of more therapeutic interventions, including DBT. Because the work became harder over time, upper leadership received a lot of pushback from employees and the union, but leadership – up to the Secretary of the agency – were all aligned on the transition to a therapeutic approach. Managers felt highest levels of leadership “had our backs” as they implemented the difficult change. Ample training resource was provided to help support the significant culture change. Over the years, as fewer resources are available to support the implementation of DBT, the abundance of support has been replaced with a “every man for himself” mentality. The roll out from Echo Glen to the system at large required considerably more help and resource than what was provided. The best laid plans – development of standards for delivery of DBT to fidelity - are compromised by staff shortages and staff turn-overs. A number of the most well-trained staff left JR and joined other outside organizations, including Linehan’s training arm.

- **Insufficient Training:** They highlight that at the start of implementing DBT, staff went to 16 to 32 hours of training at one time. But now, they have a handful of trainings (coaching on the floor and case management trainings were named), but that is it. As managers, they both find it difficult to hold staff accountable for not doing DBT if they have not been trained in the model. While some trainings exist, they simply do not have the staff sufficient to provide coverage.
- **Consultation Team/Didactic:** They follow the standard of dedicating one-hour weekly to each but “nine times out of 10, people have to leave to transport a kid”. The quality of consultation team is also compromised by the lack of training in DBT: “How do you do true consultation without knowing DBT?”
- **Variability In DBT Delivery by Site.** In some locations with well trained staff (those trained in the early days of DBT, “(their) girls are getting DBT to death”. But other locations with newer staff don’t have the same resource. Youth are receiving DBT skills mode as set forth in the standards. Yolanda is new to Touchstone where the staff is not trained and where there have been higher rates of turn over. There, youth are not (yet) receiving DBT.
- **Recommendations for Improvement.** Personnel felt that it is imperative to reduce staff turn over and increase training in order to fulfill the JR standards. That may begin with a significant wage increase to compete with other less stressful jobs that pay comparable wages.

**ECHO GLEN CHILDREN'S CENTER:** I met with senior officials on November 27, 2019 at Echo Glen. At the time of that report, six of eight cottages were providing ITM Case Management/Counseling as specified in the standards. In the two that didn't meet the minimum standard, they are not far off (approximately 70% in those two settings). With respect to group, the standard is met in 60% of the cases, which may be due to a failure to document actual groups that are occurring. Groups however were described as "not adherent to DBT...we don't really know how adherent they are". With respect to consultation team, each manager at Echo Glen is required to run a consultation team, but realistically, "a lot of things compete for the time" including reviews for youth. She estimates that 50% of the units are conducting consultation team 80% or more of the time, but that they are not adherent to DBT. With respect to case management, personnel highlighted that with staff turn-over, they have fallen "way off": "New people coming in just don't have training before they can get it. Staff that have had training are tired, burned out and cut corners". In comparison to comparable services at other facilities, Echo Glen "scores off the charts" on fulfilling the specific behavioral targets for environmental adherence.

I asked interviewees in their view contributed to Echo Glen's overall success at rolling out DBT. They highlighted the following factors:

- They began a pilot project with the most challenging cottage that had the poorest outcomes. Rather than rolling it out to the whole system, they started small and demonstrated positive outcomes that caused other cottages and leadership to take notice.
- They began with a high degree of buy in from top echelons of leadership. The system's commitment to DBT fidelity was demonstrated through "tons of training and support".
- Echo Glen *slowly* moved DBT to other cottages after Copalis outcomes provided a proof point.
- As they systematically rolled DBT out to other cottages within Echo Glen, those cottages had the ample DBT expertise (Dr. Henry Schmidt and Brad Beach) onsite to provide immediate, in the moment coaching and support.

Several current challenges make it now difficult to replicate these earlier conditions:

- Staff turn-over has been particularly hard the past two years: "It's so hard to keep staff around here".
- System does not provide Echo Glen or other facilities with the level of training, supervision, consultation, and support to keep staff adherent, as well as motivated to do DBT. In total, the system has three DBT consultants, only one of whom is certified by the DBT-Linehan Board of Certification. No onsite expertise is available for in-the-moment consultation of difficult situations. (One system leader is required to fill in for what Diana Frey and Henry Schmidt used to do).
- The push to do DBT is no longer collaborative but is now top down. (Please note that this is my interpretation of a more complex nuanced discussion).

**CONSULTANT INTERVIEW.** I spoke with consultant on Friday, November 29, 2019. I reviewed my understanding of what I had learned to date. She commented, "That is spot on." She also described her and the team's approach to training and emphasized that there is more need for training and consultation than she and her colleagues can themselves fulfill. She is also clearly passionate about her work, cares deeply about supporting JR staff, does her absolute best to develop and deliver new training content to address their needs, and is highly competent and skilled at both doing DBT and training JR staff in DBT. We also discussed several specific questions she had for me.

**OTHER OVERALL COMMENTS/THEMES:** Several themes emerged repeatedly by people at all ranks and at every facility I spoke with. These themes are described below:

**Problem of Staff Turn Over:** Many had observed that recent leadership “didn’t sound the alarm fast enough” to address the problem. Until recently, wages were described as “deplorable” for the demands placed on them, the transportation burden (most facilities are in rural locations without easy access to public transportation), and the fact that the youth coming into program were increasingly more complex. A recent 8% wage increase has helped, but not fully solved the problem. The benefits and other “perks” that made employment by JR an easy choice for many are now gone, but are not replaced with higher salaries (wanted by many younger employees in the labor market today).

**Staff Burn Out.** As many well-trained people have left or retired, it has placed greater stress and strain on those who are left – to work harder and assume more responsibility. These efforts are overlooked by leadership. Additionally, the backbone of service delivery at JR (counselors) were not included in the most recent salary negotiation, thus compromising their own morale.

**Solution for Training:** Universally, people pointed to staff shortage as being one of the biggest factors that interferes, but not the only factor. The overall investment in training, consultation, and supervision is insufficient for the volume of counselors expected to provide DBT. Additionally, of the three DBT consultants, only one JR consultation staff is perceived universally as a DBT expert in doing and teaching DBT. She is the only one that is, for example, certified by the Linehan-DBT Board of Certification. While the online materials are available, staff either do not have time to access them or are not motivated to do so.

## APPENDIX A: QUESTION INFORMING REPORT

Washington State JR provided the following questions for consideration during my visits and to guide the summary of my findings.

1. Are youth being appropriately matched with treatment based on need?

- a. What assessment is being used for program eligibility?
- b. Is the assessment being used appropriately?

*You are not being appropriately matched to the treatment model. The current model is that all youth will receive comprehensive DBT. The system however is ill-equipped to deliver on its promise because of staff shortages. As a result, few if any youth receive comprehensive DBT. Please see recommendations. Unless the system wishes to invest significant financial resources to train its workforce in DBT to fidelity (in all modes), a better approach would be to provide comprehensive DBT to those with the greatest need – either those with the most severe and complex emotion-based mental health problem and/or those who do not show progress receiving the standard care as usual.*

2. Is the treatment high quality?

- a. How well is JR implementing this treatment?
- b. Are youth receiving the appropriate dosage?
- c. Do staff receive the correct type and amount of training?
- d. Does there seem to be variation by location? (between institutions, between institutions and community facilities)

*Please see attached report.*

3. How well is the treatment integrated with the assessments, other treatments, and reentry planning?

*While DBT is well integrated environmentally and with other treatments provided, there is no means of determining which patients are more complex and difficult to treat and need more full-fidelity DBT. As noted above, it is simply not feasible that full-fidelity DBT (to adherence) is delivered to every youth in this context of severe staff shortages and high rates of staff turn-over, combined with limited and sustained comprehensive training.*

4. Does the current quality assurance plan adequately measure the treatment model?

*More emphasis is required for recording of actual counseling sessions.*

5. Do you see any evidence that would concern you that treatment access varies by race, ethnicity, age, or gender?

*No evidence.*

6. What recommendations do you have to improve implementation given the current level of resources?

*Please see recommendations.*

7. What additional resources would you recommend to improve treatment quality and integration?

*Please see recommendations.*

8. JR will be serving youth up to age 25 in the future. What advice would you give the agency as they prepare to provide this treatment for older youth?

*Recommendations will help ensure overall excellence of clinical care, including those who are older.*

## Appendix B: Materials Reviewed

### 1. DBT Standards

- a. **DBT Standard 1: Individual Counseling Sessions for DBT and ITM.** Sessions are to be provided no less than one time weekly. Specific counseling tasks are delineated for two treatment phases: pre-treatment phase and treatment phase. Specific tasks for each phase are adherent with standard DBT therapy sessions. Each phase includes facilitating youth's engagement in treatment and establishing rapport with youth. The treatment phase is fully consistent with the structural tasks required of an adherent/competent therapy session. Those who access this standard from within the JR firewall are able to access a Pre-Treatment Session Guide and a Treatment Session Guide. (I was unable to access these documents).
- b. **DBT Standard 2: Consultation Team and Didactics.** Consistent with this mode of treatment as specified by Linehan, the function of this mode is to enhance the capability and motivation of those engaged in youth care. Consultation team is described to enhance case-carrying counselors' ability to conduct treatment and build collaboration around treatment delivery. It is an expectation that those who have direct client contact will "review and comply" with this standard. Consultation teams are to meet at least once every other week and are to be led by a DBT consultant at least once monthly. Didactics are to also be provided at least every other week for case-carrying counselors and facilitated by trained staff and/or the DBT consultants.
- c. **DBT Standard 3: Milieu Management.** This standard specifies the environmental, milieu-based procedures used to support the youth with behavior change and progress with program goals, and in their transition to the community. It includes daily routines, treatment groups, use of consistent rules, and enjoyable activities. Three levels of reinforcement are specified for the milieu: material (token economy), environmental/relationship (peer support), and intrinsic (self-motivation). Staff are instructed to interact with and coach youth based on their individual developmental and skills level, culture, and current emotional state; and to work with youth to generalize their work from individual and group sessions to the milieu. This includes "coaching on the fly" strategies and "consultation to youth" (vs. environmental intervention) approaches.
- d. **DBT Standard 4: Skills Groups.** This standard for skills training indicates that all JR youth should attend group at least once weekly and that a consistent structure is used to conduct the groups. This structure is fully adherent to DBT. Groups are divided between skills acquisition and strengthening. (The document indicates that the focus is on skills acquisition and generalization, but by definition, this is more likely strengthening and not generalization). All modules of DBT are incorporated, including Middle Path – an adaptation for adolescents by Miller, Rathus, and Linehan. The standard recommends that each group is taught by two staff, but allows for a single facilitator when two staff are unable.
- e. **Integrated Treatment Model (ITM) Standard 2: Supervision.** The focus of this standard is the supervision of rehabilitation-focused case management and counseling activities. Supervisors are required by this standard to provide once monthly supervision to all

direct reports. The scope of this standard is beyond the supervision, monitoring, and/or adherence of DBT, but does include require that supervisors ensure their reports are properly onboarded to the JR expectations for delivery of DBT and other evidence-based approaches, and that their reports engage in the required training. Performance reviews also include an ITM focus.

2. JR DBT Training Materials:

- a. ***Milieu Treatment - DBT Coaching on the Floor.*** This two-day training is comprised of a total of 93 slides and focuses on use of behavioral principles and strategies to support skillful behaviors in youth and successful reentry. Topics include the DBT's biosocial theory, DBT assumptions, validation levels and strategies, modes and functions of DBT treatment, review of behavioral principles, mindfulness skills, distress tolerance skills, interpersonal effectiveness skills, motivation and commitment strategies, STOP and TIPP skills, problem-solving strategies, and opportunities to practice. The slides are thorough and accurate.
- b. ***Case Management: Reducing Risk Factors and Shaping Skillful Behavior with High Risk Youth*** (Winter, 2019). This comprehensive 150-slide training begins with an overview of working with high-risk offenders, then breaks down treatment tasks required in pre-treatment phase and treatment phase of DBT. Pre-treatment includes tasks required by counselor in advance of meeting with youth (review of their history, offense) as well as tasks required to complete in the first two to four sessions. Emphasis is placed on *how* to engage youth (empathy, validation) as well as topics the counselor must address in the first four sessions. This includes a behavioral chain analysis of their committing offense, commitment strategies, and goal setting to have a life worth living. To ensure motivation by youth to engage in treatment, linking the youth's goals to treatment tasks is also emphasized. Trainees learn details of a behavioral chain analysis and are provided opportunities to observe a demonstration and practice. Individual counseling session therapy tasks are reviewed. These include: targeting, use of the diary card, and building a shaping plan. Day 2 focuses on the treatment phase, including the structure of the session, use of behavioral chain analyses, skills coaching, change strategies (contingency management, cognitive modification, exposure, skills training), how to respond to dysfunctional behavior that occurs in session, and RTM meeting purpose/agenda. Throughout this training, attendees also learn how to document their findings and content from sessions. (As an outsider, it seems that this is a lot of content to cover in two days, and seems more consistent with what could be done in twice the time). DBT content is accurate.
- c. ***Teaching DBT Skills to Support Skillful Behavior and Successful Retry*** (Summer 2019). This training focuses on learning all the DBT skills, how to structure up the DBT group, and the standards for skills training. Discussion is also provided for how to manage difficult moments in group. While a small point, the concept of skills strengthening and skills generalization seem conflated. A fantastic cognitive map of all the DBT skills is included. Only one slide is devoted to emotion regulation.

3. Examples of Additional Training Support: A series of files were provided by Ted Ryle and reviewed as part of this evaluation. They include:

- a. **Steps for Leading a Mindfulness Practice.** This content is fully consistent with training materials developed by Linehan's training organization, Behavioral Tech, LLC and includes helpful, specific examples for youth. The content is fully accurate.
- b. **Skill of the Week Index.** This two-page document indexes the application of JR's Skill of the Week program. It represents a comprehensive review of all DBT skills.
- c. **How to Navigate the Skill of the Week.** This seven-page document provides a thorough guide (text and screenshots) to accessing the plethora of JR materials for their 25-week skill of the week curriculum available through the JR Homepage (JR SharePoint). A month-at-a glance calendar displays the skill of the week. Clicking on the calendar event brings the user to a description of content long with PDFs of associated skills curriculum documents. A legend allows viewer to see what's new or what's been recently improved.
- d. **How to Use DBT Skills Facilitator Notes.** This seven-page document is a guide for using another important resource: the DBT Skills Facilitator Notes. JR has essentially pulled together content – basic and advanced – for the teaching/facilitation of each group. Content is culled from the two gold-standard DBT skills training manuals: Linehan's second edition revision and the Rathus/Miller skills training manual. Clear and accurate instructions are provided for how to structure the skills training session, from soup to nuts. A listing of DBT consultants is also provided for assistance if needed (by facility).
- e. **DBT Skills Facilitator Note: Week 1 Mindfulness.** This is an example of the rich, DBT adherent materials skills trainers receive in order to teach DBT skills group easily and simply, without a lot of prep. It goes through exactly what to do and what to say, discuss for the topic – for the entire group. It includes suggested activities, how to orient the youth to the class today, the main points to be discussed, handouts, activities, and recommended homework. What's fantastic is that the content is pulled from multiple sources: Linehan, Miller and Rathus.
- f. **Mindfulness Activities.** This 38-page document is filled with very specific mindfulness activities appropriate for youth. Each includes a description of how to do the activity, the specific mindfulness skill the activity emphasizes, and instructions for debriefing the practice. This content is fantastic, thorough, accurate, and would make a great publication for others working with this population. This represents an example of the supporting skills documents that are available within the JR Homepage.
- g. **How to do Behavioral Rehearsal.** This incredibly important accurate two-page document summarizes the steps in doing behavior rehearsal well. This document allows the counselor to conduct behavioral rehearsal in a group context.
- h. **Weekly Email of DBT Skill of the Week.** In addition to the incredibly rich JR Homepage, counselors receive a weekly email describing the skill of the week in detail. Illustrations and real-life, relevant examples are provided to increase the odds that viewers will pay

attention to and review the document. To make it easy, a number of links are embedded to relevant SharePoint documents.

- i. ***DBT Skills Flow Chart.*** This single slide is a beautiful, accurate, and easy to follow cognitive map of all the DBT skills. It's a very helpful tool for people just learning the skills for the first time.

## APPENDIX C: QUALIFICATIONS OF REVIEWER

Linda A. Dimeff, PhD, is Chief Scientific Officer at the Evidence-Based Practice Institute, Inc; Institute Director at Portland DBT Institute, Inc., and Clinical Faculty in the Department of Psychology at the University of Washington. Since 1994, Dr. Dimeff has collaborated closely with Marsha M. Linehan to develop and evaluate an adaptation of DBT for substance-dependent individuals with borderline personality disorder; to produce DBT training materials for clinicians; and to train, consult, and supervise clinicians in their practice of DBT. She has worked with public and private sector systems throughout the world in their efforts to implement DBT. Dr. Dimeff is a recipient of the Cindy J. Sanderson Outstanding Educator Award from the International Society for the Improvement and Teaching of DBT. Linda has received over 20 federal grants to facilitate the dissemination of evidence-based therapies and has published over 55 peer-reviewed publications. She is also the first author of *Brief Alcohol Screening and Intervention College Students*.

**Appendix E:** Implementation Assessment of Functional Family Therapy and Functional Family Parole  
by Dr. Holly Barrett Waldron

## REPORT TO THE LEGISLATURE

Fidelity Assessment of the Integrated Treatment Model (ITM):  
Functional Family Therapy (FFT) and Functional Family Parole (FFP)

Holly Barrett Waldron, Ph.D.  
March 16, 2020

The Washington State Legislature designated funding for a fidelity assessment of the Integrated Treatment Model (ITM) to inform the implementation of services the Washington State Department of Children, Youth & Families (DCYF) provides to youth in the Juvenile Rehabilitation Parole (JRP) program. This report addresses the implementation of Functional Family Therapy (FFT) and Functional Family Parole (FFP) services delivered within JRP. The assessment of FFT and FFP implementation involved site visits to three geographically diverse JRP programs, interviews with administrators, program managers, and staff, and a review of materials (training materials, reports, research studies, documents specifying policies and procedures for FFT and FFP implementation). Areas addressed in evaluating FFT and FFP implementation include how well youth are matched to FFT and FFP services, the quality of treatment services, the integration of treatment services with other JRP and external services, quality assurance monitoring, and potential variations in FFT and FFP service delivery for subgroups of youth. The report concludes with recommendations for improvements achievable within the current available resources and other recommendations for needed improvements that require additional funding to accomplish. The qualifications of the author of this report are also provided.

### **Matching Youth with Treatment**

The fidelity assessment of the Integrated Treatment Model (ITM) for Functional Family Therapy (FFT) and Functional Family Parole (FFP) services includes an examination of the extent to which youth in JRP are being appropriately matched with treatment based on need. The matching process incorporates a consideration of the assessment used to determine program eligibility and the appropriateness of the assessment implementation.

In addressing these issues, the determination of the State of Washington legislature that half of all incarcerated youth will receive services through JRP while the other half will not is a critical factor. This determination presumes that youth re-entering the community either have a need for services or they do not have a need for services and that these two groups of youth are orthogonal and non-overlapping. This may be an efficient way of allocating limited resources, but is not a valid approach for matching youth with needed services.

Currently, 50% of youth eligible for parole are placed in a JRP program. This placement includes all youth who committed an offense that is legislatively mandated to include parole and youth eligible for parole who score in the top 25% of an actuarial risk assessment. The risk assessment scores guide the placement, although staff have some flexibility to place some youth in JRP who would not have been included based on their assessment scores alone because of a perceived risk due to family environment, behavioral health risks, or other factors. This flexibility is intended to ensure that youth most in need of JRP services receive them. Unfortunately, the risk assessment is an internally developed instrument that has not been validated. Without validation, the accuracy of placements is unknown and significant numbers of youth may be underserved due to scores that result in no JRP placement upon reentry into their communities, while many other youths at lower risk may be placed in JRP. More

importantly, any validated assessment tool – even an assessment that would provide a finer grained measure of youth functioning across a number of domains (i.e., severity of behavioral problems, mental health functioning, family and peer relations, and school/occupational needs prior to youth re-entry) would likely have serious limitations in determining which youth would benefit most from JRP services.

Overall, any risk assessment and ultimate placement decisions likely account for a small to moderate amount of the variance in identifying youths who should receive JRP services, as there is likely considerable overlap across youth placed and not placed in JRP. That is, the assessments scores for all youth released from incarceration occur along a continuum without a known, definitive threshold for predicting which youth are in need of or will benefit from JRP services. The placement of 50% of re-entry youth in JRP, with the other 50% not placed, is arbitrary and likely produces potentially overlapping bell-shaped distributions of need for services among youth who *do* and who *do not* receive services through JRP. Prior studies have suggested that nearly half of all youth who released with no parole aftercare services have identified mental health needs and the vast majority of these needs go unmet (Belenko et al., 2017; Washington State DSHS Report, 2017; Zajac et al., 2015). It is likely that a significant number of non-placed youth are in need of monitoring and have significant reentry needs for services that would be best provided by JRP programs.

Monitoring and providing services to non-placed youth would likely result in substantial savings to the state through decreased recidivism and re-incarceration (see meta-analytic studies of juvenile reentry intensive aftercare: Bouchard & Wong, 2018; James et al., 2013; see also FFP studies: Lucenko et al., 2011; Risk, 2009; Sexton et al., 2013). Thus, because many youth who are not placed in JRP will recidivate and experience significant problems after reentry, it cannot be concluded that youth are wholly appropriately matched with services. Although the current assessment protocols appear to be implemented with integrity and the assessment process seems to be a critical guide in determining how services such as FFT, wrap-around services, job assistance, housing, and transportation, *within* JRP would be allocated, the use of the assessment approach for determining who receives JRP services and who does not is an inappropriate and fiscally inefficient strategy for ensuring the positive transition of youth during the reentry and post-reentry period.

### **Quality of Treatment**

Another issue in examining the fidelity assessment of the ITM for FFT and FFP services concerns treatment quality, including how *well* JRP is implementing these interventions, whether or not the appropriate dosages are provided, the adequacy of the training staff receives, and the extent to which treatment services vary by location within the JRP program and between JRP and community programs and facilities.

### ***Quality of FFT***

As a whole, the FFT therapists appear to be performing at a uniformly exemplary level, given the restricted resources available to them. Without exception, all of the FFT therapists participating in the site visits associated with this report demonstrated the high levels of knowledge and skills required for effective FFT implementation. Treatment dosages for youth and families who receive FFT appear quite good, with number of therapy sessions and rates of treatment retention and completion for FFT providing solid indicators of FFT quality. Engagement in FFT is a shared responsibility across reentry and other program staff, FFP counselors, and FFT therapists. Engagement appears to vary widely across JRP sites. Some program managers and staff reported communicating to youth and families that FFT is an optional service and expend little effort to engage youth and families in treatment. Other program managers and staff reported that participation in FFT is actively encouraged and pursued vigorously using FFT engagement and motivation strategies to achieve high levels of family engagement in FFT. The lack of cross-site consistency in efforts to engage families in FFT represents a significant weakness for the FFT implementation program.

The overall quality of FFT within JRP ranges from moderate to high, but is diminished to varying degrees by different levels of administrative support provided across sites, the amount of FFT supervision/consultation therapists receive, and the amount of time therapists are required to allocate their efforts to other areas of responsibility. Across JRP sites, the FFT caseloads of five families is low and therapists' skills and specialized training are not being applied optimally to help youth during the reentry process as therapists spend significant amounts of time traveling to meet with youth and families in distant locations. Moreover, the structure of placing FFT therapists in the role of supervising FFP counselors is detrimental to both FFT and FFP implementation quality because FFT therapists are responsible for overseeing FFP fidelity for counselors who do not directly report to them and who are formally supervised by others who conduct their performance evaluations. This situation gives FFP counselors the option to follow or reject the guidance of FFT therapists, limiting the impact of therapists' time and skills.

FFT quality is also diminished somewhat by the lack of systematic training for all therapists in all elements of the ITM. Because therapists are not systematically included in trainings for Dialectical Behavior Therapy (DBT) and Aggression Replacement Training (ART), two interventions included within the ITM intended for delivery to all youth during their period of incarceration, therapists do not have full knowledge of the clinical tools youth have been exposed to while incarcerated and cannot optimally guide youth to fully develop and implement these tools as situations arise once they transition to their community environments.

Finally, traveling to distal sites to conduct FFT sessions with families is burdensome for the system and diminishes the time available to provide services to youth in need of treatment. The limitations on numbers of youth who receive FFT lowers the overall quality of FFT implementation.

### ***Quality of FFP***

The treatment quality of FFP appears more variable, relative to FFT quality, ranging from low for FFP counselors with seemingly limited commitment and fidelity to the FFP approach and moderate for counselors who seem to have embraced the FFP model and appear motivated to implement FFP with integrity. Hampering treatment quality for FFP is the inadequacy of training, beyond the initial FFP training, the supervision structure, and fidelity monitoring procedures.

Basic training in the FFP model appears to be excellent. Collectively, the trainers are experienced in FFT, FFP, other evidence-based interventions, working with juvenile justice involved youth and their families, and adolescent behavioral health. Although FFP counselors appear well grounded in the FFP approach, they are not exposed systematically to FFT training, limiting their ability to understand the work the FFT therapist is engaged in with youth and families. This limitation compromises the ability of FFP counselors to use that knowledge to collaborate with FFT therapists on goals for youth and families to help consolidate and apply the skills they are learning as they navigate the reentry period. As with FFT therapists, FFP counselors also are not provided with systematic exposure to DBT and ART training. Without a broader exposure, counselors are not fully able to understand the clinical tools youth have been taught and guide youth to further develop and implement these tools as situations arise after they transition to their community environments. Additional training in specific areas of substance abuse treatment and trauma coping strategies, problems affecting a significant proportion of youth in JRP, is also lacking.

### ***Treatment Implementation Variations Across JRP Locations***

With respect to variations in treatment services across JRP sites, dramatic differences were readily apparent for FFT implementation across sites. Relatively fewer cross-site differences observed for FFP. There were also some differences noted as to how FFT and FFP link youth and families with community programs and facilities. However, these differences appear due to the variations in resources available across different communities. For example, the urban and rural settings have different resources for housing, food, and other needs. In more remote areas, matching youth to vocational development opportunities may also be sparse, compared to opportunities in larger communities and urban areas. These variations appear unrelated to FFT and FFP implementation across sites.

### **Integrating FFT and FFP with Assessments, Other Services, and Reentry Planning**

The integration of FFT and FFP with assessment and reentry planning appears very strong. The assessment information is an important factor, though not the sole determinant, for deciding which youth and families are deemed most appropriate for and in need of FFT services. Similarly, the assessments provide a unique source of valuable information to guide FFP.

Overall, the integration of FFT and FFP with other interventions and services *within* JRP varies widely, depending on the thoroughness and frequency of case staffing meetings with the entire services staff in attendance and the effectiveness of communication across staff within each site. Some sites have a rigorous process for integrating FFT, FFP, and other interventions and services for youth through their weekly staff meetings and regular review of all cases. These programs are exemplary. Other programs do not follow a process that ensures a regular review of all cases and a climate that fosters regular communications between staff to ensure effective coordination of services.

The integration of FFT and FFP with other interventions and services *external* to JRP is challenging, especially with the current resources available. The wrap-around services program provides a model for the integration of FFT and FFP with other interventions and services, but is labor intensive, costly, and available for only youth at the highest levels of risk for recidivism and recurring problems. Thus, the current level of integration of FFT and FFP with other treatments outside JRP appears appropriate.

### **Adequacy of Quality Assurance Plan**

Given that high competent adherence of clinicians to evidence-based treatment models has been empirically linked to better youth and family outcomes, while poorer adherence has been associated with poorer outcomes and higher recidivism rates, the adequacy of the quality assurance plans for FFT and FFP are crucial for maintaining clinician and counselor adherence and maximizing the effectiveness of the ITM. Both FFT and FFP have basic quality assurance plans in place and all sites appear to be highly compliant with quality assurance procedures. Thus, quality assurance measures are completed and this provides useful information about staff and program activities. The adequacy of the quality assurance plans, however, are limited by the general lack of specificity with respect to how sub-optimal FFT or FFP adherence is addressed. Moreover, the validity of the adherence measure, the Global Rating Measure (GRM), for measuring FFP adherence is quite weak.

For FFT, the quality assurance procedures measure the fidelity of implementation of the treatment model moderately well. The initial training and subsequent experience of therapists, combined with clinical tracking system provided by FFT training program provides a minimum level of quality assurance. If adherence declines, however, it is unclear what steps are taken to guide therapists and help them return to acceptable adherence levels. The process for delivery of feedback to therapists is unclear and there are no observation-based quality assurance procedures in place by which a supervisor, trainer, or consultant would provide guidance to help therapists regain adequate fidelity. Supervision and consultation opportunities for FFT therapists appear minimal.

For FFP, the limitation of the GRM is that, as indicated by the title, ratings cover broad swaths of counselor activities, providing a general and likely imprecise approximation of counselor behavior and performance over all sessions conducted within a 90-day window or, initially, within a 30-day window. The GRM is completed by the FFT therapist who participates in FFP implementation at each site. Because the GRM involves an overall set of ratings of the FFP counselor's fidelity across multiple youth/families and across all

FFP sessions observed or co-led by the FFT therapist in the prior 30 or 90 days, the ratings essentially become a measure of relatively stable counselor “traits” rather than an assessment of the degree to which FFP is being implemented with fidelity in any given meeting the counselor has with youth and families. Because the global rating approach tends to aggregate specific observations of FFT behavior into a broad picture of performance, the adherence measure does not capture instances of specific areas of strength or areas in need of improvement. Moreover, because the FFT therapists do not have a direct supervisory role in relation to FFP counselors, their ability to provide corrective feedback is hampered and their influence on performance is weakened unless a very strong bond between the therapist and counselor have been forged. Such bonds were present within some sites visited and absent within others. Given the observation that commitment to the FFP model was somewhat variable across program staff, the need for strengthening the role of the FFP supervisory position is clear.

### **Variations in Treatment Access by Race, Ethnicity, Age, and Gender**

Throughout the fidelity assessment of the ITM, there was no evidence of any kind that FFT or FFP was implemented with systematic variability across youth race, ethnicity, age, or gender. The site visits included attending FFP field meetings, meetings that included a diverse mix of youth with respect to race, ethnicity, age, and gender. FFP was implemented consistently and adherently across all youth and families observed. All interviews and interactions with staff across the three JRP sites visited and all materials reviewed are consistent with the conclusion that there is no variation in FFT or FFP implementation by race, ethnicity, age, or gender.

One caveat to this conclusion is that it is possible that racial/ethnic minority youth may be overrepresented among families with fewer socio-economic resources who, due to higher housing costs closer to JRP sites in city or town centers, may reside in more distal areas within each region. Such a situation would make it more challenging to provide services to youth in outlying areas with the same frequency as youth residing closer to the JRP facilities. JRP staff, program managers, and administrators uniformly recognized the need to provide services to youth at the same level, regardless of their proximity to program facilities and expressed the commitment to ensure comparable quality and frequency of services for those youth living farther away. A significant problem that contributes to the increased potential for minority youth to receive fewer needed services, however, is the limit the State of Washington places on FFT therapists and FFP counselors for mileage reimbursement and policy restrictions that limit travel.

### **Recommendations for Improving Implementation**

The recommendations for improving the implementation of FFT and FFP within the ITM are based on the issues noted in previous sections. Improvements in implementation in many areas are feasible with the current level of resources provided to parole aftercare. A primary concern is that only half of the youth are placed in JRP upon their release from incarceration. JRP could have a far greater impact if each region maintained oversight and supervision of *all* youth re-entering their communities. Within such an approach, the

assessment process could guide the allocation of FFT, the amount of contact youth and families have with FFP counselors, and other JRP services.

Although this would require a systemic change at the legislative level, such a change could be initiated at a minimal level without an increase in funding. Some JRP sites already strive to serve youth not formally placed within their oversight, juggling resources internally to cover needed services. In addition, costs associated with assessment, placement, and reentry planning for two groups of youth could be re-distributed to JRP programs to allocate internally. As noted above, monitoring and providing services to non-placed youth would also likely result in substantial savings to the state through decreased recidivism and re-incarceration. Although attempting such a change without an increase in funding would not produce optimal results, the empowering JRP to allocate resources across the single continuum of need would help guide the application of current resources more efficiently.

Supervising all youth transitioning to the community would double the overall number of youth served, but would not require a doubling of the workload for JRP staff. A substantial number of lower risk youth would need less monitoring and could be supervised with monthly FFP check-ins and brief phone contacts. Similarly, youth with moderate risk, including those who would have been placed in JRP and those who would have been released without JRP placement, could be supervised with bi-weekly FFT check-ins, with phone contacts as needed, while higher risk youth could receive services as they are now provided by JRP. Allowing adjustments in service allocation to be made internally by JRP would significantly enhance the quantity and quality of services across all youth. Because all youth not placed in JRP are released from incarceration with some arrangement for housing, funding for housing services would not necessarily need to increase.

Another issue that could be improved is cross-site consistency of FFT and FFP implementation. The development of checklists, procedures, and/or benchmarks to monitor cross-site consistency could help to ensure that comparable levels of family engagement in FFT are achieved across sites, the frequency of reviews of cases by all staff are consistent across sites, and comparable services and treatment dosages are delivered to equivalent proportions of youth and families across sites. Possibly, supplemental training and consultation may be needed to assist sites with lower FFT engagement rates to improve FFT implementation. In addition, changing the supervision structure so that FFT therapists who guide FFP counselors also have a meaningful role in supervising counselors, contributing to their performance reviews, and providing input into merit increases would provide much needed support for maintaining more cohesive teams of counselors and enhance FFP fidelity.

A more rigorous fidelity monitoring measure is needed to improve the quality of FFP. Rather than using the GRM as a gross measure of FFP adherence across sessions, families, and longer periods of time, the GRM could be adapted as a brief tool that requires only a few minutes for counselors to complete at the end of each session. On co-visits, the FFT therapists would also complete the brief tool and a supervision could include a review of counselor and supervisor adherence forms as a focus for feedback

and coaching. Adherence tools have been developed for FFT using mobile app technology to save therapist time, maximize efficiency, and lower costs for sustaining fidelity. Such tools could easily be adapted for an FFP adherence measure, yielding an approach more similar to the adherence procedures completed by FFT therapists.

Implementation of FFT and FFP could also be dramatically improved at relatively low cost (i.e., release time for therapists and counselors) allowing all therapists and counselors to attend or “audit” ongoing trainings for DBT and ART. Such a step would ensure FFT therapists and FFP counselors all have a basic knowledge of a broader set of interventions provided within the ITM intended for all incarcerated youth. FFT quality could be improved by expanding therapists’ knowledge of the clinical tools youth have been exposed to while incarcerated to better guide youth to fully develop and implement these tools as situations arise once they transition to their community environments.

### **Additional Resources to Improve Treatment Quality and Integration**

Some improvements for FFT and FFP will require additional funding. One readily apparent area for improvement is the need for additional personnel. The number of FFT therapists and FFP counselors is inadequate. The quality assurance of FFT could be enhanced significantly by creating teams of two or more therapists within each JRP site, providing regular supervision (e.g., weekly) and consultation (e.g., monthly) for these therapists, and providing expanded opportunities for observation-based coaching and feedback. This would improve FFT quality, within-site cohesion, and expand treatment to more families. With more nimble therapists with advanced training in key areas of behavioral health (i.e., - see training recommendations below) auxiliary support staff or community professionals funded by the state to service this population and currently providing substance abuse or mental health treatment could be reduced to allow for the addition of FFT therapists. Additional FFP counselors are also needed at all sites to improve the frequency and duration of FFP sessions with youth and families. By expanding the FFT and FFP staffing levels, overall program cohesion would be increased as the number of specialty staff decreases and the FFT and FFP teams provide a coordinated and integrated set of services.

Another clear need is funding to increase FFT and FFP staff salaries. FFT therapists in JRP are paid less than FFT therapists in other branches and divisions of the state government. Lower pay means the best staff leave to take higher paying positions in other departments and the disparate pay contributes to lower morale. Parole counselors in JRP are among the lowest paid in the adult or juvenile justice system. Comparable, competitive pay for FFP counselors is essential to attract and retain the top staff and sustain effective evidence-based programs.

The travel restrictions and mileage reimbursement limitations specified by state policies hamper the delivery of FFT services. When FFT travel limits have been reached, therapists are compelled to find creative ways (e.g., “borrowing” unused miles from staff with lower travel requirements) to meet the needs of youth and families. One solution would be to provide additional resources to FFT therapists for travel. This solution does

not address the issue that time spent traveling restricts the number of youth FFT therapists can serve. Because of the long distances that must be traveled to meet with youth and families in all regions throughout the state, tele-health capability is needed to expand the reach of FFT and FFP to more youth and families and increase the frequency of contacts and total treatment dosage for youth. Tele-health programs have been used effectively throughout the country and would allow for many more FFT and FFP sessions to be conducted via secure video conference than is currently possible. Tele-health capability would allow for considerable increases in FFT and FFP caseloads and allow staff skills and specialized training to be applied more efficiently to help youth during the reentry process.

Training FFT therapists and FFP counselors to integrate strategies from evidence-based approaches, particularly interventions for substance abuse treatment, depression, and trauma-focused interventions representing the greatest areas of unmet need among youth in JRP, would dramatically improve the treatment quality and expand the impact of FFT and FFP. In addition, training auxiliary program staff in FFP would strengthen the overall cohesion within each JRP site. Additional training for FFT and FFP staff would reduce the need for WISE services and specialized staff to provide substance abuse or other treatment services, resulting in cost savings. The FFT and FFP models are designed for flexibility and can be tailored to meet a wide range of needs of youth and families. FFT has systematically been implemented and evaluated as a substance abuse treatment (Waldron et al., 2001; Waldron & Turner, 2008; Waldron, Brody, & Hops, 2017) and the strategies for treating youth who are substance-involved could readily be integrated into FFT throughout JRP, eliminated the need for independent substance abuse counseling staff and making more efficient use of resources. Similarly, FFT strategies for depression and trauma-related problems are well developed and specialized training for FFT therapists would help diminish the need for more intensive services, including individual psychotherapy and some wrap-around services.

Another essential improvement would be to add capacity within each JRP site to conduct data analyses to monitor program performance (treatment quality, quality assurance, FFT and FFP outcomes) internally. Having analytic tools and staff to use them would allow sites to make adjustments and improvements more flexibly and nimbly than is possible when relying on independent studies to be conducted and fidelity assessments to be completed when the data become less useful. Having technology in place to support electronic entry of adherence ratings would provide immediate access to reports, facilitating analysis needs at low cost and supporting internal tracking and program sustainability.

### **FFT and FFP for Emerging Adults Served by JRP**

The period of emerging adulthood for youth between the ages of 18 and 25 is one of rapid and extensive transitioning as youth experience physiological, sexual, cognitive, and emotional changes. Emerging adults often take on new adult roles and responsibilities, including advanced education or occupational training, entry into the workforce, exiting their family home, forming new intimate relationships, and starting their own families.

Many young adults also move into new adult roles and responsibilities. They may begin higher education studies, enter the workforce, move away from home, or start a family. They will experience increased opportunities to make their own decisions, including legal decisions, and take on increasing or exclusive financial responsibility for themselves.

This period is often overwhelming, but is expected to be particularly difficult for youth challenged by reentry into their communities. It is not surprising that currently more than a third of youth released from incarceration to live with their families of origin are reportedly no longer living with those families six months later. A significantly greater percentage of reentering youth aged 18-25 are likely to live away from their families and have less social support from their families unless concerted efforts are made through FFT and FFP to strengthen familial connections. JRP resources will undoubtedly be strained heavily by the expanding of services up to youth age 25, particularly because these youth will not only continue to need all of the services currently provided within JRP, but these youth will have fewer safety nets for the basic needs of food and shelter. JRP should anticipate escalating challenges to facilitate housing, transportation, community services (e.g., food banks), and resources for employment and occupational development for these older youth. The family is a key source of support to alleviate the burden that JRP will experience, thus ensuring high quality FFP for all youth and expanding FFT to a greater portion of youth in need of treatment services will empower families as partners to meet the challenge.

### **Qualifications**

The author of this report, Holly Barrett Waldron, Ph.D., has an extensive background in FFT and prior experience with FFP that qualify her to conduct a fidelity assessment of the FFT and FFP components of the ITM. Spanning four decades of work, she has been an FFT innovator and model developer, training and supervising hundreds of FFT therapists in the United States and in Latin America. She is proficient with the FFP approach through her prior work with the FFP development team, experience designing clinical trials to evaluate the effectiveness of FFP, and consultations with juvenile services departments considering the implementation of FFP. Currently, Dr. Waldron is a Senior Scientist and the Director of the Center for Family and Adolescent Research at the Oregon Research Institute. She is also the President and CEO of LIFT, Co., an organization focusing on technology transport and implementation services, expanding the reach of evidence-based treatments and training programs for youth with co-occurring behavioral health problems. Dr. Waldron is a licensed psychologist (New Mexico License 1825) and has more than 35 years of clinical, research, and treatment dissemination experience. She has worked extensively with children, youth, and families to address behavioral health problems using evidence-based treatments. She has also collaborated with the Juvenile Justice System, schools, and other community programs for youth to help troubled youth. As a researcher, she has led many treatment development programs and randomized clinical trials examining family-centered and cognitive behavioral therapies for adolescent substance use disorders, depression, disruptive behaviors, trauma-related problems, and HIV risk behaviors. Her treatment research efforts have also focused on evaluating parenting approaches, contingency management, motivational interviewing, juvenile

justice interventions, and web-based treatments. As a scientist-practitioner, Dr. Waldron is actively engaged in implementation science research and treatment dissemination activities. Her current dissemination and research activities focus on the use of technology to improve the efficiency and lower the costs for FFT training, supervision, and fidelity monitoring. She has also developed an FFT tele-health service delivery approach to enhance the reach and sustainability of FFT and other evidence-based treatments in community-based treatment settings nationally and internationally.

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**Appendix F:** Implementation Assessment of Aggression Replacement Training  
by Dr. Andrew M. Fox

Implementation Assessment of Aggression Replacement Training in Washington State's Juvenile  
Rehabilitation

April 2020

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Office of Innovation, Alignment, and Accountability  
Department of Children, Youth, and Families

### About Aggression Replacement Training (ART)

Youth violence has a significant impact on communities in America. There are continuing efforts to identify treatment programs to reduce youth violence. One such program is Aggression Replacement Training (ART). The program was originally designed for hostile and assaultive youth who were incarcerated. The program is a 10-week psycho-educational intervention. A series of prosocial behaviors are taught through a structured leaning environment to small groups of 6 to 8 youth. The training consists of three components, social skills, anger control, and moral reasoning. In 1987, Glick and Goldstein first demonstrated that ART reduced the number and intensity of behavioral incidents of youth while in the institution and showed that youth were able to apply and transfer these skills after transferring into the community. This program showed promise and has been implemented in many different settings in the decades since its original implementation. Adaptations have included school settings, family-based, and for youth on the autism spectrum (Roth, 2003; Calame, 2003; Moynahan, 2003).

In 2016, Brannstrom and colleagues conducted a systematic review of the literature. They identified 16 studies that examined the impact of ART on recidivism, primarily. The review concluded that, “the primary studies of ART do not provide a sufficient base for substantiating the claim that the program is effective for reducing antisocial behavior in adolescents and adults” (pg. 40). Among the major concerns was that almost half of the studies were completed by researchers who had a vested interest in the program. Additionally, the methodological rigor of the current body of research is limited. CrimeSolutions.gov rates ART as an effective program<sup>1</sup> based on two studies (Barnoski, 2004; Gundersen and Svartdal, 2006), however, more recent research is not conclusive about the effectiveness of the program.

In Washington State, there has been significant investment in ART. The program was first implemented for justice-involved youth in 1999, in a community setting. It was later expanded and implemented within the state juvenile residential facilities in 2008. There have been a series of studies on Washington State ART (WSART), with the most recent studies causing concern about the effectiveness of the intervention. In 2004, Barnoski evaluated WSART by comparing youth who started the program in 2000 to those who were eligible, but were on the waiting list due to a lack of available resources. The study found that ART resulted in a marginally significant reduction in 18-month recidivism; however, for those courts that were determined to have administered WSART competently, there was a significant reduction in felony recidivism. This finding highlighted the importance of implementation fidelity.

In 2017, using propensity score matching, Peterson (2017) compared youth who started WSART to those who did not receive an evidence-based program. While the author notes some data limitations, the study found that youth who started ART had higher felony recidivism than a matched control group. Most recently, in 2019, Knoth, Wanner, and He, using a sample from 2006 to 2016, found that WSART participants were significantly more likely to recidivate than matched youth who did not participate in the intervention. The authors compared WSART to a

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<sup>1</sup> <https://www.crimesolutions.gov/ProgramDetails.aspx?ID=254>

treatment as usual group using propensity score matching. Further, the authors found that the trainer competence score did not have an effect on the results.

All the findings on WSART come from the implementation through the courts. Little is known, however, about the effectiveness of the program for juveniles in residential programs. The training, quality assurance protocols, and assessments in the Juvenile Rehabilitation institutions are identical to those that have been used in the courts, with youth who are in the community. The current assessment explores the implementation of ART in the three JR institutions (Echo Glen Children's Center, Green Hill School, and Naselle Youth Camp). From January 2008 to December 2019, JR had over 3,200 starters in ART in one of the institutions. For this assessment, all manuals, quality assurance plans, training materials, and surveys were reviewed. Additionally, the ART administrator, JR master trainers, and national experts were interviewed for their insight on the current implementation of the program in JR specifically, and the model more generally.

### **Assessment questions:**

The current assessment seeks to address the questions listed below. These are common questions that were asked about all the treatment areas in the Integrated Treatment Model as part of the current fidelity assessment.

1. *Are youth being appropriately matched with treatment based on need?*
  - a. *What assessment is being used for program eligibility?*
  - b. *Is the assessment being used appropriately?*

In Juvenile Rehabilitation the Integrated Treatment Assessment (ITA) is used to determine eligibility for Aggression Replacement Training (ART). The ITA is a risk and needs assessment that is administered within 14 days after admission into a JR residential facility. The assessment is similar to the Residential Positive Achievement Change Tool (R-PACT), which has been studied extensively. However, JR has yet to validate the weighting of the ITA for the JR population. Nevertheless, ART in JR uses the eligibility criteria identified by WSART (which is implemented in the courts, with youth living in the community). Specifically, to be eligible for ART a youth must have a high score in domains: 1 (record of referrals), 10B (current attitudes and beliefs), 11 (aggression), and 12 (skills).

It is encouraging that JR is using the ITA to determine eligibility for ART. This follows the risk-needs-responsivity model (RNR). The RNR model is comprised of three principles. First the risk principle, which suggests that those with the highest risk for reoffending should be prioritized for treatments and other interventions. Second, the need principle recommends that the individual needs of each youth are determined, specifically those needs are most likely to be associated with criminal behavior. And third, the responsivity principle requires that the correct type of programming be offered based on an individual's risk and need profile (Crits and Taxman, 2013; Brogan, Haney-Caron, NeMoyer, and DeMatteo, 2015). In ART in JR, the use of the ITA indicates that there is some attention being paid to the need and responsivity principles of the RNR model.

None of the research reviewed indicates that the current eligibility criteria is predictive of future violent behavior, which would require ART as an appropriate treatment. The current

program is using an assessment for eligibility, and the assessment is being used appropriately, however, JR has not determined that the eligibility criteria that have been selected are appropriate. The research has not determined who will benefit the most from the program. JR needs to inform staff of when ART is the best response, given a profile of risks and needs of a youth. If the program has the wrong eligibility criteria, an outcome evaluation might determine the program is ineffective, when the reality is that the program was given to the incorrect youth. The program needs to answer, which youth need ART and which youth can ART impact the most? The answer to these questions will help JR refine their eligibility criteria, and ensure that resources are used most efficiently.

*2. Is the treatment high quality?*

- a. How well is JR implementing this treatment?*
- b. Are youth receiving the appropriate dosage?*
- c. Do staff receive the correct type and amount of training?*
- d. Does there seem to be variation by location? (between institutions, between institutions and community facilities)*

JR appears to be implementing the treatment according to the design. There are strong training and quality assurance protocols in place. In terms of dosage, all those who start the program receive the same dosage, which is three sessions per week for 10 weeks. It is not clear whether youth are receiving the right dosage. It is likely that some youth require more treatment and some less, however, the current design of ART does not allow for this type of dosage variation. JR should consider a graduated or extended course of ART for those youth with greater need and who are at a higher risk for future aggression. There was some reporting that ART is only allowed 45 minutes for sessions in some places due to school schedules. This would result in a lower dosage than intended. There is variation by location in terms of when ART is administered but the standards and quality assurance for the program is consistent across location.

*3. How well is the treatment integrated with the assessments, other treatments, and reentry planning?*

The current implementation design does not include much integration of the assessment or integration with other treatments or reentry planning. Assessments are used to determine eligibility, however, they are not used during ART to determine dosage or focus, since it is a group based program. ART has a unique set of skills that are different from Dialectical Behavior Therapy (DBT), and there is little to no training for staff on how the two sets of skills overlap or are complementary. Generally, living unit staff have not been trained in the ART skills and are not able to reinforce youth who use the ART skills.

*4. Does the current quality assurance plan adequately measure the treatment model?*

WSART has a well-established quality assurance plan. Facilitators submit a recording of a session annually and this session is evaluated by a master trainer. As a result, the facilitator is

determined to be adherent to the model or not. There is a youth survey in place, however, this is not be administered on a routine basis. The program also has an established curriculum for training new trainers, monthly consultation conference calls, site visits and feedback from the ART administrator, and semi-annual quality assurance committee meetings.

While there are well-established quality assurance protocol currently in place, there is not a process to determine whether the program aspects being monitored are related to improved outcomes. ART in JR needs to establish which implementation metrics are most associated with improved outcomes so that the treatment administrator can monitor those metrics on a regular basis.

5. *Do you see any evidence that would concern you that treatment access varies by race, ethnicity, age, or gender?*

I do not see any evidence that treatment access varies by race, ethnicity, age, or gender. Youth in JR have had pretty broad access to ART.

6. *What recommendations do you have to improve implementation given the current level of resources?*

There are a number of recommendations that could be started immediately, with little to no additional resources. First, the eligibility criteria should be better defined. Currently, any youth with a score above zero in any of the specified domains is eligible for ART. Low scores in these domains indicate lower risk. JR should set cut off values for a more clear eligibility criteria, that will allow staff to prioritize those youth with the greatest risk and the most need in this area. Clearly, research will need to inform these criteria in the future, but in the short term, these can be made more clear.

The number of youth who get ART should be based on need and not predetermined quotas. This can be a challenge when trying to plan for treatment capacity, but ultimately need should drive capacity planning. More treatment is not always better; instead, the correct treatment is best. JR should refine the eligibility criteria so that it is based on evidence accumulated over the past 10 years of implementation, and then focus ART on those with the most need and the highest risk.

At some of the institutions, because of the school schedule, only about 45 minutes is permitted for the ART sessions. Staff should reconsider how ART is being implemented to ensure a full hour for programming for ART sessions, to ensure implementation fidelity.

7. *What additional resources would you recommend to improve treatment quality and integration?*

The first priority is to better understand how well ART is working in JR. Given recent findings that suggest an iatrogenic effect of ART when administered in the community with justice involved youth, JR should first ensure that this is not the case with those receiving the treatment in residential facilities. Next, research should investigate the optimal eligibility

criteria. Programming will be the most effective when matched to the youth with the risk and need profile most appropriate for the treatment.

JR should set up a curriculum review committee for ART, but this could be for the ITM more generally. This committee would be responsible for reviewing treatment curricula and ensuring that they are up to date and relevant. Many of the lessons in ART have been in place for decades, and experts need to have a process to review their content to make sure they are culturally relevant for the target population. Lessons can be reviewed on a rotating basis, so that over the course of a few years, the entire curriculum is reviewed and updated.

JR needs to implement a process that will allow for closely monitored variations of ART programming. For example, JR could test a shortened version of ART for youth who have the need and are high risk, but do not have a very long sentence. JR could also start to explore options for a graduated course for youth with longer sentences, who need additional reinforcement of the ART skills. This might include an alumni group that continues to meet so that the skills can be reinforced. There is also some discussion of whether an 8 week course could be just as effective for youth. These are all important considerations, and JR needs to have a process to continue to learn about what is most effective for youth who are high risk and have the need to reduce aggression. These types of variations would need robust evaluation protocols to help determine both the strengths and challenges of each.

*8. JR will be serving youth up to age 25 in the future. What advice would you give the agency as they prepare to provide this treatment for older youth?*

The first consideration is the assessment used for ART eligibility. The ITA was developed for juveniles and validation work has not been done for an adult population. JR needs to determine whether the risk and need profile of a juvenile is the same as the profile for an adult, in terms of whether ART is the appropriate program. Also, some stakeholders have indicated that ART has been offered in the Department of Corrections. As youth are brought back to JR from DOC, case managers need to identify if an individual was already taken ART in DOC. Individuals should be re-assessed to determine the treatment that will address their current needs.

*9. Please provide a statement of qualifications.*

Andrew M. Fox is a Senior Researcher in the Office of Innovation, Alignment, and Accountability in the Department of Children, Youth, and Families. His work is focused on Juvenile Rehabilitation in Washington State. His research interests include delinquency, gangs, crime prevention, program evaluation, social network analysis, and communities. Dr. Fox has served as the research partner on a number of federal initiatives, including Strategies for Policing Innovation, Innovative Prosecution Solutions, and the Police-Prosecution Partnership Initiative. He was previously an assistant professor of criminology at the University of Missouri-Kansas City and California State University, Fresno. He received his Ph.D. and M.S. from Arizona State University in Criminology and Criminal Justice. Some of his work has been published in *Crime and Delinquency, Justice Quarterly, Police Quarterly, and the American Sociological Review*.

**Appendix G:** Implementation Assessment of Treatment for Youth Who Sexually Offend  
by David Prescott

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## **Introduction**

This brief report summarizes findings from an assessment of programming delivered to children and adolescents in the care of the Washington Department of Children, Youth, and Families (DCYF). Specifically, this assessment reviewed policies and practices specific to youth who sexually offend. It concludes that the DCYF has developed a very good platform of care that is in line with best practices and the most recent research. This report offers suggestions for making this programming better still. This report summarizes what the author stated to DCYF administrators on December 2 and 3, 2019.

By way of context, I (the author) have produced numerous books, book chapters, and articles in the area of understanding, assessing, and treating sexual violence. I've trained and lectured in these areas around the world, and my work has been translated into five or more foreign languages. I am the 2014 recipient of the Distinguished Contribution award of the Association for the Treatment of Sexual Abusers (ATSA) and the 2018 recipient of the C. Henry Kempe Lifetime Achievement award from the National Adolescent Perpetration Network.

The questions that this writer was tasked with included:

1. Are youth being appropriately matched with treatment based on a risk-needs-responsivity framework
  - a. What assessment is being used for program eligibility?
  - b. Are assessments being used appropriately?
2. Is the treatment high quality?
  - a. How well is DCYF implementing this treatment?
  - b. Are youth receiving the right dosage?
  - c. Do staff receive the correct type and amount of training?
  - d. Does there seem to be variation by location?
3. How well is the treatment integrated with the assessments, other treatments, and reentry planning?
4. Does the current quality assurance plan adequately measure the treatment model?
5. Is there evidence that treatment access varies by race, ethnicity, age, or gender?
6. What recommendations are there for improving implementation given the current level of resources
7. What additional resources are recommended to improve treatment quality and integration?
8. What advice is there for serving youth up to 25 years old? What kinds of preparations can DCYF make?

## **The Broader Picture: Program Assets and Attributes**

The DCYF program, particularly as delivered in its inpatient facilities, emphasizes a strong skills-based approach using empirically supported treatments such as Dialectical Behavior Therapy and Aggression Replacement Training. The administration retains a number of consultants to ensure that these

treatments are provided with fidelity to the model. In a cursory review of the programs, this was in evidence (for example, the author observed part of a treatment group and found evidence of treatment lessons on the walls of programs, serving as helpful reminders to the clients). This integration of solid treatment approaches into the milieu speaks to the level of intensity of the services provided.

It was obvious through interviews with program staff in several locations that the administration very genuinely cares about effective treatment for the youth in their care, and for the safety and wellbeing of those the same youth have harmed. There is no program measure for this; rather, the author is comparing our interactions with those in other programs inside and outside the US in similar assessment processes. Program administration, almost by definition, means balancing often competing elements (such as ensuring quality of care within a tight budget). It can be very easy for administrators to err on the side of appearances rather than the substance of effective treatment programming. It was very clear that the current administration has the youth (and families) they serve at the top of their priorities. This is a crucial asset that should be recognized.

DCYF programming involves a sophisticated electronic medical record that appears to be effective for its current needs. As is always the case in these matters, it is not perfect and people have occasional reason to complain, but on balance the program materials are in place and accessible. This is not often the case in other programs.

Likewise, the “golden thread” of information between treatment plans and case notes was in place and effective. The author reviewed a number of treatment plans and case notes on a random and semi-random basis and found that none were problematic, and that the structure of each allows for continuity of treatment communication. In other words, case notes reflected treatment plans, which in turn reflected the medical and/or psychiatric evaluations from which they were drawn as well as the legal documents for each youth. Case notes were generally well written and the treatment plans themselves reflected and enabled an individualized treatment approach for each youth in treatment.

Particularly impressive was the separation of group treatment interventions from the kind of deeper discussions about offending that take place in private. There is a wealth of research showing that group treatment with youth is most effective when it is highly structured, and that in-depth discussions about topics such as family relationships and offense disclosure are best left to individual counseling sessions. Again, this is not always the case in programs.

Further, the program is currently working to refine its programming in accordance with developments elsewhere in the field. In particular, the program is working to improve its capacities in trauma-informed care and the use of treatment goals that clients in treatment can “approach” rather than “avoid”. Very simply put, a body of research finds that people are motivated by goals that they can acquire and achieve rather than those they must avoid. “Having a balanced, self-determined lifestyle where I can get what I want without hurting people” is far more desirable to people who have abused than “Living by a set of rules that will make it impossible for me to re-offend.”

Finally, although the author was able to interview two clients directly (one randomly), it was clear through observation that the youth I observed were engaged within the program. Likewise, the staff with whom I interacted (some by chance, others by design) were committed to their work.

On balance, there is much to be proud of within this branch of DCYF services.

## Challenges

The number one concern expressed by all interviewed is that the treatment provided within the inpatient components of the program is not provided by licensed clinicians. Although the programs are assisted by psychologists, the treatment itself is delivered by people who do not have specialized training in psychotherapy. This point needs to be understood in the proper context: the programs themselves have accommodated this fact to the best of their abilities. As mentioned above, the inpatient-based treatment is highly structured and skills-based, with the deeper psychotherapeutic practices taking place after the clients return to the community. Many of the primary approaches by which treatment is provided, DBT and ART, can be administered by professionals who are not licensed to provide psychotherapy under the right conditions. However, there is little question that the inpatient programs could become more effective with the inclusion of licensed mental health practitioners. This is in line with the most recent meta-analytic research by Theresa Gannon and her colleagues on the effective treatment of adults convicted of sex crimes. In that study, the presence of a licensed psychologist providing treatment was one of the defining factors of effective treatment programs. In the author's opinion, finding clinicians is likely the greatest need for the DCYF programs in the long term. As a part of these efforts, it should always be kept in mind that this is highly specialized work where public safety and the health and welfare of young people hang in the balance.

The second most cited concern is staff turnover. This is an issue that bedevils programs around the world. The wages are rarely competitive, while the demands are stringent, the clients caustic, and accountability is high at all levels. Despite children and adolescents being a particularly vulnerable population and the potential threat to public safety of uncared-for youth returning to the community, this remains a challenge for DCYF and other programs.

The third most cited challenge is the upcoming influx of clients between the ages of 18 and 25 due to changes in policy. The author suspects that the logistical aspects of this change will be more difficult than adapting the clinical program, but it is understood that this will be a challenge.

A large-scale challenge for the programs is that they are very often in a position where providing adequate treatment is simply not an option. The author heard many instances in which clients were in placement for only a brief period of time. Under these conditions, it can be difficult to chart a meaningful way forward, since some forms of treatment can make matters worse when terminated early. The DCYF program for youth who sexually abuse will want to develop alternative programming in these situations where time is limited. One option may be to develop a comprehensive assessment for future providers and to include the youth as much as possible in the process so that he can, in essence, help to assess his own life and determine the difference between where he is and where he wants to be.

Finally, although the programs that the author were generally clean, there was some degree of clutter in offices and on desks (piles of paperwork, boxes for board games, etc.). The programs would benefit from some "sprucing up".

## Areas for Consideration

To this point in the review, it is clear that the basic materials of the DCYF program generally comport with current best practices, and that the challenges faced are not, on balance, unusual compared with other programs. What follows are recommendations for strengthening the clinical components of the program.

First, the program's push towards trauma informed care (TIC) will be welcome, and I suggest giving it top priority. To that end, a book chapter on the topic is attached to this report in case it is helpful. As the administration knows, TIC is a paradigm for treatment that recognizes the widespread effects of trauma and seeks to prevent *re-traumatization*. This last idea is important, as even the best designed programs can be re-traumatizing under the wrong circumstances. It is often difficult for outsiders to understand the effects of institutions and institutional life on young people.

Next, the programs will wish to increase the amount of contact that clients have with their families while in inpatient care. This can include family-oriented interventions or simply increasing contact. Factors that appear to hinder progress in this area include that clients and their families often appear alienated from one another and don't necessarily press for closer contact. This can lead program staff to the faulty assumption that family contact needn't be a priority. Actively taking the lead in including families (often the province of clinical staff), and maintaining their involvement, could go a long way towards preparation for community re-entry as well as contributing to healthier functioning for families. Although every family is different, one option that could be considered is the use of videoconferencing through HIPAA-compliant platforms such as Zoom.

Further, the staff of the programs would benefit from ongoing training in collaborative, person-centered approaches such as motivational interviewing. Although the staff receive training in related areas such as de-escalation, focusing on communications for daily interactions can also improve outcomes. It is to DCYF's credit that programs have a small nucleus of staff who have natural talents in this area, typically cultivated over years of practice. Active training in this area would behoove DCYF and its clients alike.

The DCYF programs can also consider the use of Routine Outcome Monitoring (ROM) to track outcomes related to client wellbeing and program effectiveness. The author recommends using an approach such as Feedback-Informed Treatment (FIT), which includes easy-to-use measures in tracking changes in wellbeing and in the therapeutic alliance. Together, these measures can offer information that can predict when cases are heading off track and provide evidence that treatment is working. FIT also provides insights for professional development. As easy as it can be to import and use these measures, sustaining implementation can be a challenge (as it is with any other evidence-based practice) and improvement of services can take time. ROM can be hard work.

The DCYF programs will also benefit from continued adaptation to special-needs clients. This includes those with developmental delays and those on the autism spectrum. The author is aware that efforts in this area are under way.

One area to consider is how best to address issues related to viewing adult pornography. Although the law prohibits youth under 18 from viewing pornography, it is nonetheless ubiquitous. Further, this will become even more of an issue once the influx of young men and women 18-25 arrive in programs. Clearly, DCYF will not allow pornography use in its programs. However, some degree of education can serve an important function in building healthy masculinity and responsible sexuality. One place to start might be in the use of the Savvy Consumer model (<https://blog.atsa.com/2019/10/the-savvy-consumer-guide-for.html>).

Likewise, although sex education can be controversial, clinical interventions targeting sexual responsibility can be highly useful in preventing re-offense. One option might be these materials by Joann Schladale: <http://resourcesforresolvingviolence.com/publications/>.

Finally, as a part of creating holistic, trauma-informed treatment, it may be useful to include adjunctive “embodied” treatments such as trauma-sensitive yoga and trauma-sensitive weightlifting. The programs already contain a mindfulness component, and so these could be helpful additions to the existing suite of interventions.

### **Summary Judgments**

The questions that this writer was tasked with included:

1. Are youth being appropriately matched with treatment based on a risk-needs-responsivity framework
  - a. What assessment is being used for program eligibility?
  - b. Are assessments being used appropriately?

The short answer is that the answers are “yes”. However, as noted above, the circumstances of each youth’s involvement can prevent the strictest adherence to these principles. For example, if a higher-risk youth is only placed in the facilities for two weeks, this prevents an adequate period of stabilization and may compromise the risk principle. In some cases, youth may be kept in inpatient care longer than the treatment team might otherwise wish for and have to wait for the more intensive level of services provided by outpatient practitioners. Within the scope of their mandate, however, the program works diligently to adhere to these principles.

The assessment methods for the inpatient treatment are appropriate for the services provided. Because the more thorough clinical work happens in community settings, the methods used for eligibility are appropriately idiographic. In other words, they are balanced assessments of each youth and their current behavioral needs. In the context of DCYF, they are used appropriately.

2. Is the treatment high quality?
  - a. How well is DCYF implementing this treatment?
  - b. Are youth receiving the right dosage?
  - c. Do staff receive the correct type and amount of training?
  - d. Does there seem to be variation by location?

The overarching answer is “yes.” Given its resources, DCYF’s implementation efforts are admirable. Its primary asset in implementation is its use of consultants to ensure fidelity of treatments such as DBT and ART. This is something that the Clinical Director appears to take very seriously. The dosage question is addressed throughout this report, with the ultimate answer being, “Yes, within the context of parameters that the programs can control.” Due to the nature of the curricula delivered, it appears that the staff members do indeed get the correct type and amount of training, with suggestions offered above on how this might be improved. The variation of training appears commensurate to the special needs of each location, indicating that although there is some variability, it is in the service of adaptation to the unique needs of each setting.

3. How well is the treatment integrated with the assessments, other treatments, and reentry planning?

Overall, the integration of assessment, treatment, and re-entry planning, especially in the context of DCYF's available resources, is quite clever and innovative. The assessments are individualized and serve as the basis of treatment in the programs. Further, the clinical leadership ensures continuity of care between the inpatient and outpatient components of the programs. A random review of documents found that each was well-written and displayed clear evidence that each component of treatment built on the others. Treatment notes clearly reflected the assessments, and re-entry planning clearly reflected treatment. In the author's experience, this can be quite difficult to accomplish in settings such as these. This area is viewed as an accomplishment that DCYF can and should be proud of.

4. Does the current quality assurance plan adequately measure the treatment model?

Yes. The clinical administration has systems in place to ensure that the treatments delivered are done so with fidelity to the models used. At the time of this writing, the administration was looking into further developments in this area.

5. Is there evidence that treatment access varies by race, ethnicity, age, or gender?

No. In fact, the author was impressed by how members of the staff and administration talked about their efforts in these areas. The nearest to disparity that the programs get is that clients in treatment are disproportionately from minority backgrounds, while clinical staff are disproportionately white. However, there was no evidence that even this made a marked difference in the treatment experience of the youth.

6. What recommendations are there for improving implementation given the current level of resources

As mentioned earlier in this report, advancements in the areas of trauma-informed care, motivational enhancement, and the further development of approach goals would be welcome.

7. What additional resources are recommended to improve treatment quality and integration?

On-site clinicians for treatment provision in the residential programs would be ideal, although it is noted throughout this report that this has been very difficult to accomplish historically.

8. What advice is there for serving youth up to 25 years old? What kinds of preparations can DCYF make?

Clearly, the clients served by DCYF vary dramatically not only in their physical age, but also in their developmental abilities. This will doubtless also be true with the transitional age clients that are soon to arrive. Important to remember is that adolescents do not become adults overnight at the age of 18, and so services for these clients, like those who are younger, will need to be developmentally appropriate.

Areas of consideration will include:

- Discharge/re-entry planning will need to occur from the start of treatment, with an additional focus of finding community housing and employment that has historically been less of a focus with adolescents. Locating community resources can be a challenge. Some agencies have hired

people who specialize in locating housing and employment for these clients. This will likely be the biggest challenge that DCYF faces.

- Likewise, preparing clients for community challenges such as housing and employment will also be vital. One possible resource that can help to guide efforts during re-entry is the *Circles of Support and Accountability* model.
- In support of the point above, all interventions that focus in the area of interpersonal competence will be welcome. A key goal can be helping clients to experience themselves as competent in a wide range of situations and relationships, able to relate to others empathically. This is often less of a focus with younger adolescents who are working more towards school and family re-entry.
- DCYF may wish to consider policies as to what extent, if any, clients can view adult pornography and/or consume alcohol towards the end of their involvement with the agency. In the author's experience, different jurisdictions have different policies in these areas.
- Sexual arousal/interest patterns do start to become more clearly established during this time. Consideration for the assessment process will include the use of a viewing time measure such as the LOOK Assessment or Abel Assessment of Sexual Interest. Although the author uses the LOOK (<https://www.lookassessment.com/>) in his practice, there can be pros and cons to each, and DCYF will want to consider the finer points, including cost and clinical utility.
  - For clients with strong abuse-related sexual interests, DCYF will wish to consider the use of specialized behavioral treatments to help these clients manage their thoughts, fantasies, urges, and behaviors. Although these treatments on their own are not known to be effective over the long term, a recent meta-analysis has found that programs that contain behavioral treatments appear to produce better outcomes. This is an area in which more research is needed. Based on the available research, the overarching focus with these clients should be in helping them to manage their behaviors. There is no research to date showing that treatment can consistently or reliably change their underlying sexual interests. In other words, treatment can't reliably change what people like, but it can help them change their behavior around what they like. All of this said, these clients will likely be in the minority of DCYF's population; the point is that sexual interests become more entrenched in adulthood.
- Depending on circumstances, adult risk assessment measures such as the Static-99r, Stable-2007, Acute-2007, and SOTIPS become more appropriate for these young adults, and given the numbers of developmentally challenged clients served, DCYF may also want to consider the ARMADILLO (<http://www.armidilo.net/>). One of that tool's authors, James Haaven, is based in Oregon.
- The programs' treatment approaches, such as ART, DBT, and (possibly) TARGET can be used with adults as well as adolescents, with some modification. Likewise, Motivational Interviewing can be used with clients of all ages.
- A broader approach of trauma-informed care will also be important, as described earlier.

I hope this overview and suggestions are useful to the competent and committed staff of the DCYF programs for youth who have sexually abused.

Respectfully submitted,

*David S. Prescott, LCSW, LICSW* (signed electronically)

David S. Prescott, LCSW, LICSW

**Appendix H:** Implementation Assessment of Specialized Treatment for Substance Abuse  
by Dr. Susan A. Stoner

# Integrated Treatment Model: Specialized Treatment for Substance Abuse in Juvenile Rehabilitation

*Report to the Washington State Department of Children, Youth & Families*

March 2020

Susan A. Stoner, Ph.D.

## Introduction

The State of Washington has long been concerned with appropriate treatment of justice-involved youth. In 1999, Washington State's Juvenile Rehabilitation (JR) implemented a competency-based model of treatment and case management for justice-involved youth, focusing on increasing youth accountability, skill development and measuring youth changes in skill areas throughout their involvement with JR.<sup>1</sup> In 2000, an effort was undertaken to further define and specify appropriate interventions to be used with youth in residential care and with families as the youth return to their home communities.<sup>1</sup> This effort gave birth to the development of a research-based Integrated Treatment Model (ITM). The ITM was intended to be effective through attending to motivation and engagement of both youth and families, adopting a commonly understood language to be utilized throughout the juvenile justice continuum, teaching a uniform set of cognitive-behavioral skills, promoting generalization and maintenance of positive changes, and providing for ongoing clinical consultation system to ensure continuity of interventions and adherence to the model.<sup>1</sup> The model is described in depth elsewhere.<sup>1</sup> In brief, treatment strategies incorporated into the ITM used in residential care were derived from cognitive-behavioral therapy (CBT), particularly Linehan's Dialectical Behavior Therapy (DBT)<sup>2</sup>, and Goldstein et al.'s Aggression Replacement Training (ART)<sup>3</sup>. Treatment strategies incorporated in the ITM used in community settings are grounded in Alexander & Sexton's Functional Family Therapy (FFT)<sup>4</sup>. At the time they were incorporated into the ITM, the listed therapeutic approaches were all considered evidence- or research-based.

Codifying the state's commitment to the use of evidence- and research-based practices, the Washington State Legislature passed E2SHB 2536 in 2012, mandating that "prevention and intervention services delivered to children and juveniles in the areas of mental health, child welfare, and juvenile justice be primarily evidence-based and research-based, and...provided in a manner that is culturally competent."<sup>5</sup> To aid enactment of the mandate, the Legislature directed the Washington State Institute of Public Policy (WSIPP) to conduct standard meta-analytic and benefit-cost analyses to classify relevant programs as "evidence-based," "research-based," and "promising." Such classifications inform eligibility for state funding.<sup>6</sup>

Compared to general treatment for youth in JR, specialized treatment for substance use disorders (SUDs) in justice-involved youth has not achieved a comparable level of integration and standardization despite having been a focus of JR in Washington State for nearly 35 years.<sup>7</sup> Unfortunately, there exists no uniform SUD treatment model or functioning oversight committee in place to guide the implementation of SUD assessment and treatment in juvenile justice settings in the state.<sup>7</sup> The Substance Use Disorder Oversight Committee was disbanded to incorporate into the newly formed Behavior Health Quality Assurance Group. However, this did not prove successful in addressing the many needs of SUD services. As such, the SUD Oversight Committee was reinstated. Significant variation exists among SUD treatment programs across institutions, creating the potential for treatment content and quality to vary by institution and making it difficult to compare and monitor programs.<sup>7</sup> A recent study by the Washington State Department of Children, Youth & Families (DCYF) examining SUD treatment

needs in JR concluded that efforts to standardize SUD treatment process and ensure youth are receiving the same quality of treatment across institutions could facilitate program evaluation, support continuity of services, and assist in improving outcomes for youth.<sup>7</sup>

Such efforts are important because SUD treatment needs are consistently high in justice-involved youth in the state. DCYF researchers found that, between 2014 to 2018, roughly two-thirds of youth in JR showed a need for SUD treatment each year and such need consistently exceeded residential treatment capacity.<sup>7</sup> During the examined time frame, only 56 percent of youth with identified substance use needs started residential SUD treatment, with an average of 185 youth per year not receiving needed residential SUD treatment.<sup>7</sup>

Against this backdrop, DCYF sought the input of a consultant to help examine fidelity of the evidence-based interventions incorporated into DCYF's Integrated Treatment Model for JR as it relates to specialized treatment for substance abuse. The consultant was contracted to conduct an assessment of the quality of treatment that currently exists in JR by visiting at least two of the three juvenile rehabilitation institutions, one community facility, and one parole office. The assessment was required to address the following questions as they are related to the Specialized Treatment for Substance Abuse in JR:

1. Are youth being appropriately matched with treatment based on need?
  - a. What assessment is being used for program eligibility?
  - b. Is the assessment being used appropriately?
2. Is the treatment high quality?
  - a. How well is JR implementing this treatment?
  - b. Are youth receiving the appropriate dosage?
  - c. Do staff receive the correct type and amount of training?
  - d. Does there seem to be variation by location? (between institutions, between institutions and community facilities)
3. How well is the treatment integrated with the assessments, other treatments, and reentry planning?
4. Does the current quality assurance plan adequately measure the treatment model?
5. Do you see any evidence that would concern you that treatment access varies by race, ethnicity, age, or gender?
6. What recommendations do you have to improve implementation given the current level of resources?
7. What additional resources would you recommend to improve treatment quality and integration?
8. DCYF will be serving youth up to age 25 in the future. What advice would you give the agency as they prepare to provide this treatment for older youth?

## Method

The consultant conducted site visits at the following facilities: Green Hill School (GHS) on

December 19, 2019, Naselle Youth Camp (NYC) on December 20, 2019, Echo Glen Children's Center (EGCC) on January 2, 2020, and Woodinville Community Facility (WCF) on January 10, 2020. Each site visit lasted 2-4 hours, during which time facility staff were interviewed regarding the relevant topics. In addition, the consultant spoke with six program managers representing the parole regions across the state during their monthly meeting (via phone, January 16, 2020).

## **Findings**

As described in a November 2019 report by DCYF staff, entitled Residential Substance Use Treatment Access in Juvenile Rehabilitation in Washington State<sup>7</sup>, there is substantial variation between institutions in terms of the SUD treatment provided. However, SUD assessment practices are uniform.

### **Assessment Practices**

All youth are administered the Global Appraisal of Individual Needs—Short Screener (GAIN-SS) upon intake. The GAIN SS is a short (15-item) version of the Global Appraisal of Individual Needs, developed by Chestnut Health Systems to be used as a screening tool.<sup>8</sup> It takes approximately 5 minutes to administer, consisting of three subscales: the External Disorder Screener, the Internal Disorder Screener, and the Substance Disorder Screener (SDS). Each subscale has a maximum score of five for a total maximum score of 15. Those who screen positive on the SDS are administered a longer assessment, called the Adolescent Substance Use Assessment (ASUA), designed by JR to identify the level of severity of use for each substance used. The ASUA is adapted from the Adolescent Chemical Dependence Assessment developed by JR in 2003 and spans the six dimensions of American Society of Addiction Medicine (ASAM) criteria for SUD treatment. Administered by a certified substance use disorder professional (SUDP), the ASUA takes one to three hours to complete and produces a score that is reflective of the level of SUD treatment needed by the assessed youth.

### **Treatment Practices**

Each of the three institutions has its own model of care.

#### **Naselle Youth Camp**

NYC provides level one outpatient services, which involves individual counseling sessions once weekly for about 30 minutes, focused on 1-2 issues. Open group treatment sessions are provided a few times per week. With open groups, group sessions are ongoing with youth cycling in and out of the groups at staggered times. Alcoholics Anonymous meetings are offered twice per month. The youth's level of severity of SUD has little impact on the form or amount of treatment received. The model of treatment provided at the facility generally follows the Matrix Model<sup>9</sup> and the Adolescent Community Reinforcement Approach (ACRA-ACC) with an emphasis on education and relapse prevention. Staff noted that the Matrix Model was not originally designed for use in adolescent correctional facilities. The model has now been adapted by the original developers for a variety of correctional settings including jails,

community corrections, probation programs, drug courts, and prisons with the structure of an evidence-based treatment experience and combines education on both substance use and criminal thinking and behaviors.

At the time of the site visit, no clinical supervision was being provided and no formal procedures were in place to promote fidelity to a standardized SUD treatment model. Although JR clinical supervisors have been trained in the methods and standards for clinical supervision provided by the Matrix Model and ACRA-ACC, clinical supervision had not yet been implemented. It was noted that NYC used to have an intensive outpatient program, but that was discontinued when the population declined. Currently there are not enough staff to offer more intensive services. Staff expressed a desire for a more appropriate standardized SUD treatment curriculum and more CD staff, possibly embedded in the living units with protected time and higher pay.

#### **Green Hill School**

GHS provides level two intensive outpatient services (ASAM level 2.1), consisting of half-day closed group sessions for 10 weeks (similar to an academic quarter), called the SMART program. Cohorts of 8 youth begin and “graduate” from the 10-week groups together. Due to the closed nature of the groups, when a youth is expelled due to behavioral issues, their spot remains vacant unless it happens in the first week or two of the quarter. Care is taken not to have youth from rival gangs in the same group. GHS models the SMART program after the Matrix Model, in which staff had received specialized training, but the model has had to be adapted to the practical realities of the setting. A subset of DBT skills have been adapted for use in the curriculum as well. Staff expressed interest in examining other treatment curricula that were more appropriate to correctional settings (e.g., *A New Direction* or the *Matrix Model for Criminal Justice Settings*, offered by Hazelden Publishing,) but noted no funds were available to purchase commercial curricula. The SMART program is manualized so that different cohorts of youth have a similar treatment experience. However, there is no clinical supervision and no formal procedures in place to promote fidelity besides manualization and “checking boxes.” Staff noted there used to be peer audits, which were viewed as helpful but were no longer occurring.

Due to short sentences, some youth identified as needing SUD treatment are unable to be enrolled in groups. Such youth are given a relapse prevention workbook and met with individually as time allows. At the time of the site visit, GHS had recently hired a SUDP-T for level one opioid use disorder treatment (OUD), funded by a time-limited opioid grant. There was a desire to provide this level of care for other substances. There was also a desire for a dedicated SUD unit to provide inpatient residential treatment. Staff noted that, because marijuana use is common in the living units, it has the potential to undermine youth progress in the program. Inpatient treatment was viewed as a potential solution to this challenge.

Youth who have a positive urine toxicology for marijuana are directed to watch a video, called “Marijuana and the Teenage Brain” and to complete a self-assessment of consequences of marijuana use corresponding to the potential effects identified in the video, akin to a

motivational enhancement intervention. To the extent possible, staff have been tracking follow-up toxicology screens and finding low rates of repeat positives. This seems to suggest a benefit of the practice, but it has not been systematically evaluated. The evaluator noted the existence of the research-based intervention, the Teen Marijuana Check-up.<sup>10</sup> Staff were not aware of this intervention but expressed interest in learning about it.

#### **Echo Glen Children's Center**

EGCC provides level three intensive inpatient treatment (ASAM level 3.7), called the Exodus program, following a model of DBT for substance use disorders (DBT-S). Groups are conducted daily and individual sessions occur on a weekly basis according to a comprehensive individualized treatment plan. Length of stay depends on individual needs and progress in the treatment plan, with the average stay lasting 3-6 months. With this level of care, each group session requires the involvement of 3 staff members. EGCC has generally also offered intensive outpatient treatment, but at the time of the site visit, this level of care was not being offered due to staffing issues. Although EGCC houses males and females, inpatient treatment is provided for males only in the Kalama living unit, functioning as its own licensed agency within the institution. Because inpatient treatment is provided for males only, while intensive outpatient treatment is not being offered, it means no SUD treatment is being provided to female youth. Because suicidality and aggressivity take precedence and are treated in the living units, youth with comorbid SUDs and suicidality and/or aggressivity do not receive SUD treatment. Furthermore, some youth who did not have the high level of severity requiring intensive inpatient treatment were nonetheless receiving it because that was the only level of care offered for SUDs other than OUD. Level one care for OUD was being provided with time-limited opioid grant funding, which was viewed as a major benefit. The opioid grant has enabled following youth into the community, and this possibility was desired of other types of SUDs.

#### **Woodinville Community Facility**

Community facilities no longer provide in-house SUD treatment and variation exists in the level of care available in the communities surrounding community facilities. WCF is something of an exception as it embeds a staff member of an outside agency in the facility to provide SUD treatment, covered by state insurance. This agency uses the Seven Challenges outpatient model of treatment, which is manualized and uses standard workbooks (one workbook per challenge). The agency staff member providing the treatment has received specialized training from the Seven Challenges intervention developer and attends booster training sessions yearly to maintain fidelity to the model. The agency staff member has also received training in DBT and DBT-S in addition to training in leadership and teaching. Facility staff noted they receive annual training in suicide prevention and community safety but not in alcohol or drugs. Substance use was described as the one re-entry domain in which staff had the least training. The treatment provider is not included in Re-entry Team Meetings.

Youth entering the facility from one of the institutions have their GAIN-SS results documented in the Automatic Client Tracking (ACT) system, which is accessible to WCF staff. Those who had

screened positive for SUD are referred to the agency staff for SUD assessment and treatment. The provider conducts a full ASAM assessment. As SUD treatment records do not travel with the youth from the institution to the community facility, the provider relies on the youth to say what they had been working on in their prior treatment. Youth are taken to an outpatient setting for the treatment, which consists of 12 weekly open group sessions and 12 individual sessions. Family sessions are conducted monthly or as needed. Family sessions are advisable to the extent that they were included in the protocol of the research conducted on the effectiveness of the Seven Challenges treatment approach. Youth are subjected to random urine toxicology screens. A satisfaction survey is administered to youth at the end of treatment. Responses have reportedly been consistently positive.

### **Parole**

Youth being transitioned out of institutions or community facilities may be released to parole. When appropriate, parole is included in re-entry team meetings a month prior to release, where they typically learn about a youth's SUD diagnosis. Information about substance use is also found in the Initial Client Information to which parole has access. SUD treatment may be stipulated as a condition of parole. SUD treatment provision varies by state region and type of parole. For example, in King County, SUD treatment is generally provided by Ryther Child Center. In Snohomish County, it was noted there was a recent change in practice; after using an OUD treatment navigator to help youth with OUD find appropriate treatment, treatment navigation services were provided for other SUDs as well. Not all regions have treatment navigators, however. In some cases, a mental health coordinator helps to find SUD treatment options. Parole program managers noted that clients often lack motivation in getting help. They felt some sort of incentivization would be helpful, and there was interest in Contingency Management though this evidence-based practice was not being used. Desired incentives included housing support, gym memberships, and clothing. It was noted that CDPs were embedded in parole offices in the 1990s to serve as drug and alcohol coordinators, and this was felt to be beneficial. Program managers stated that some youth fall through the cracks as they are waiting to get an assessment in the community or waiting to secure an available bed in a treatment facility. Because data on SUD treatment in the community are not captured, treatment referrals and admission activities are not monitored consistently throughout the system.

### **Analysis**

#### **Are youth being appropriately matched with treatment based on need?**

It does not appear that youth are being appropriately matched with treatment based on need. While there is a range of levels of care provided across the institutions, each institution only provides one or two levels of care that may be dependent on what substance is being used. Assignment of youth to particular institutions is made based on multiple considerations, including age, gender, sentence length and other considerations, of which SUD prevalence/severity is not one. Youth in need of SUD treatment get the level of treatment offered at the institution to which they were remanded, regardless of their level of

need/severity. In many cases, this means youth get less treatment than they need, in some cases, more treatment than they need, and in other cases, no treatment at all.

### **What assessment is being used for program eligibility? Is it being used appropriately?**

The GAIN-SS and the ASUA are being used to determine program eligibility. They appear to be administered appropriately, but the results with regard to severity are not fully being taken into consideration due to level of care constraints at the institutions to which they are remanded, as noted above. Though modeled after a validated assessment, the ASUA is not itself validated. The ASUA was not reviewed during the course of this evaluation.

### **Is the treatment high quality?**

In general, the treatment models selected by the different programs are research-based and of high quality. However, some of the treatments used were not developed for juvenile justice settings and have had to be adapted considerably. When a treatment is adapted and applied to a different population than the one in which it was originally tested and found to be effective, it is arguable whether it can still be called evidence- or research-based. Thus, staff should be dissuaded from adding outside materials without prior vetting by clinical experts or an appropriate oversight body.

### **How well is JR implementing this treatment?**

JR appears to be implementing the chosen treatments as well as possible given the constraints of the settings. Treatments are generally manualized and delivered in the context of an individualized treatment plan. Staff are passionate about providing high quality SUD care. However, systemic issues interfere with the ability of JR to provide optimal treatment. For example, it was noted that staffing was often a problem. As noted, at the time of the site visit, EGCC was not providing intensive outpatient due to staffing challenges. As long as this is the case, no girls in a JR institution receive SUD treatment. With three staff members needed to conduct each intensive inpatient group, when one staff member is pulled into another unit by management to cover a staffing shortage, it means that youth do not receive treatment that day. Staff noted that, compared to those working in the living units, those working in SUD units require substantial additional specialized training, yet they do not have differential titles or pay, and their time conducting SUD treatment is not protected. This also affects staff turnover. Such systemic issues harm the quality of SUD care offered to youth in JR.

### **Are youth receiving the appropriate dosage?**

In many cases, the answer is no. As noted above, youth receive the type of treatment offered at the institution to which they have been remanded, regardless of severity of need. In some cases, treatment is a fixed dosage (e.g., 10 weeks at GHS), and in other cases dosage is more flexible (e.g., inpatient stay length at EGCC). Sentence length sometimes precludes receiving the appropriate dosage of treatment, making referral to appropriate ongoing care even more critical. Left to receive treatment in the community, youth sometimes fall through the cracks as they wait for a spot in a community-based program.

**Do staff receive the correct type and amount of training?**

For the most part, institution staff appear to be appropriately trained in the treatments that they are providing. However, in community facilities it was noted that substance use is the one re-entry area in which they receive the least training.

**Does there seem to be variation in treatment quality by location?**

Treatment quality varies primarily according to level of care. Higher levels of care are generally of higher quality because they allow more intensive contact with youth receiving services. As noted, the institutions vary according to levels of care provided. There is variation in treatment quality between institutions and community facilities and likely also between community facilities as community facilities have outsourced their SUD treatment provision. While the treatment provided through WCF is judged to be high quality, other community facilities may not have access to such high-quality treatment in their communities.

**How well is the treatment integrated with the assessments, other treatments, and reentry planning?**

SUD treatment is not well integrated with SUD assessment. SUD treatment is provided largely without regard to the level of severity identified by the assessment. SUD treatment does not appear to be well-integrated with mental health treatment. It appeared that degree of communication and coordination between SUD treatment providers and mental health providers varied by location. SUD treatment was also not well integrated with the treatment provided in the milieu. It does not appear that residential counselors support SUD treatment in a consistent or meaningful way.

**Does the current quality assurance plan adequately measure the treatment model?**

There was no formal quality assurance plan identified at any of the sites visited. Fidelity to the chosen treatment model was supported through manualizing the treatment and/or using standard curricula, workbooks, and/or handouts. Much more could be done to promote quality assurance, such as re-instating peer review, providing regular consultation with treatment model trainers/developers, or providing technical assistance in the form of clinical supervision or learning collaboratives. To ensure a successful quality assurance plan, it would be advisable to secure buy-in from leadership at the institutions that they will support the plan once it is implemented and refrain from deviating from established curricula without appropriate vetting.

**Do you see any evidence that would concern you that treatment access varies by race, ethnicity, age, or gender?**

There was no evidence that treatment access varies by race, ethnicity, or age. There was clear evidence that treatment access varies by gender, with the only institution serving girls providing only inpatient treatment to boys. This appeared to be a temporary situation though it was very concerning.

**What recommendations do you have to improve implementation given the current level of resources?**

- Institution staff expressed a desire for better communication with and support from behavioral health administrators.
- Short of providing SUD staff with higher pay, providing SUD treatment staff with a new title that reflects their different role within the institutions could discourage management from pulling them out of SUD care to cover for other types of staff.
- It may be possible to receive technical assistance from federally funded sources, such as the Addiction Technology Transfer Network.
- Re-instituting peer review could also improve implementation.
- Continuity of care could be enhanced by providing SUD treatment records to community facilities when youth arrive there from institutions and to community treatment providers with whom paroled youth continue their treatment. This would also save time and cost associated with re-assessment.

**What additional resources would you recommend to improve treatment quality and integration?**

- Make regular use of an SUD treatment oversight committee to guide the implementation of SUD assessment and treatment in juvenile justice settings in the state.
- Increase the correspondence between severity of SUD identified via assessment and the level of treatment provided.
- If it is not possible to make institutional assignments on the basis of level of treatment need, each institution should provide multiple levels of care to better match youth to SUD treatment according to need. This would clearly require increased staffing and expanded programming.
- Reinstating SUD treatment coordinator positions would be beneficial.
- Additional staffing could provide suicidal and aggressive youth with SUD treatment as their suicidality and aggressivity is concurrently addressed.
- The problem of released youth falling through the cracks could be addressed by providing for youth to be followed into the community, as currently happens for youth with OUD under the opioid grant. Staff at Echo Glen were particularly in favor of this and seemed to have ideas about what this might look like. For example, it was felt that Echo Glen could serve as a hub for the state due to its relatively central location.
- Funding for alternative curricula could also improve treatment quality if other treatments can be identified that better fit the constraints of correctional settings.
- Refresher training for providers in their treatment models could enhance fidelity. Curriculum review by credentialed treatment trainers could also be beneficial.
- There is a potential benefit of providing prevention education for all types of SUDs as is being provided for OUD. Marijuana use disorder prevention programming would be particularly beneficial given the increasing prevalence of marijuana use. The research-based Teen Marijuana Check-up would be advisable to examine as a possible

intervention strategy.<sup>10</sup>

- To whatever extent possible, efforts should be undertaken to promote coordination among SUD, mental health, and milieu treatment providers. 42 CFR Part 2 creates real barriers to coordination and continuity of care.
  - Could releases of information from or on behalf of youths be procured to facilitate communication among care providers? If so, beyond promoting communication among SUD, mental health, and milieu counselors, it would potentially be beneficial to include SUD treatment providers in re-entry team meetings.
  - If not, could one-way communication mechanisms be implemented where SUD treatment staff are made aware of any mental health treatment being provided?
  - In light of the high rates of SUDs and SUD treatment need in the general population of youth in JR, consider the utility of treating every youth as though he or she has an SUD. This “SUD-informed approach” could be analogous to a trauma-informed approach wherein all clients are treated as though they have histories of trauma. With respect to SUDs, this could involve bringing residential counselors into the loop regarding what youth *in general* are working on in SUD treatment. With that awareness, residential counselors could perhaps support that work by modeling such skills for all youth in the milieu. If this is not feasible, consider what an “SUD-informed approach” in the milieu might look like and whether it would look different from what approaches currently being used.

**What advice would you give DCYF as they prepare to provide treatment for youth up to age 25?**

- Treatments that are appropriate for adolescents are not necessarily appropriate for young adults and vice versa. Care must be taken to ensure treatment is developmentally appropriate.
- Similarly, screenings and assessments that have been validated and are appropriate for one age group are not necessarily valid or appropriate for a different age group. The GAIN-SS has been validated in both adolescents and adults.<sup>11</sup> The ASUA should be validated for both adolescents and young adults.
- With higher ages, sentences are likely to be longer. With long sentences, the question of timing of services should be addressed. Will programs prioritize providing SUD treatment when SUDs are at their worst (upon intake) or relapse prevention programming as youth face release from a long stint in a controlled environment?
- Among youth, rates of marijuana use in the community increase with increasing age.<sup>12,13</sup> As older youth will be served, there may be an exacerbation of marijuana use in living units in both institutions and community facilities. How this will be handled should be considered.

## **Author Note**

Susan Stoner, Ph.D., is a licensed psychologist and Research Scientist at the Alcohol and Drug Abuse Institute at the University of Washington. In 2015, she was tasked by the Washington State Division of Behavioral Health and Recovery (DBHR) to review the literature and prepare a report on evidence-based, research-based, and promising practices for adolescent substance use disorders.<sup>14</sup> In 2018, Dr. Stoner prepared a report for DBHR on evidence-based practices in behavioral health in Washington State.<sup>15</sup>

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**Appendix I:** Implementation Assessment of Specialized Mental Health Treatment  
by Dr. Sarah C. Walker



# MENTAL HEALTH TREATMENT QUALITY ASSESSMENT

Juvenile Rehabilitation Administration

March 2020

Sarah Cusworth Walker, Ph.D.

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## *JUVENILE REHABILITATION MENTAL HEALTH TREATMENT QUALITY ASSESSMENT*

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### *Are youth being appropriately matched with treatment based on need?*

**Mixed.** The Beck Depression Inventory (BDI) and UCLA PTSD Reaction Index (RI) appear to be consistently used across institutions upon a youth's first arrival at a facility. These are validated and widely used measures of mental health need and are appropriate for the age group served by JR. Both measures are appropriate for teens and adults. Universal screening using these tools allows the institutions to identify mental health needs that may otherwise not be reported or referred. This is a strength of the mental health treatment programs (Woodinville is not expected to perform independent mental health screening as they receive the youth's medical files when a youth is transferred). However, information about the use of screening and assessment information to guide specific treatment was available inconsistently across institutions and across diagnostic types.

Following referral, treatment plans are typically developed without an explicit expectation that treatment will follow clinical guidelines based on areas of elevated need identified by the assessments. My review did not include review of medical records and I cannot say how often treatment aligned with best practices, but policies were not in place to ensure therapists were aware of and expected to follow guidelines when delivering treatment. Trauma treatment at Echo Glen appears to be the only therapeutic program where an elevated score on a mental health scale (UCLA) leads to a specific treatment recommendation (Trauma-Focused Cognitive Behavioral Therapy). In addition, scales were not used to monitor the progress of treatment over time. Only Green Hill was routinely reassessing youth using the BDI and UCLA scales and this was at release and not incorporated in active treatment. One of the primary benefits of using symptom measures when developing treatment plans is to reassess progress at routine intervals and adjust the therapeutic approach, if necessary. This approach (measurement-based care) did not appear to be a systematic part of clinical care at any of the facilities.

### *Is the treatment high quality?*

**Mixed.** In this report, I interpret high quality as the explicit expectation and use of evidence-based clinical elements in psychotherapy treatment and a strategy for adjusting treatment when symptoms are not improving. I did not assess psychotropic prescription practices, use of polypharmacy or other medication management. In addition, I did not observe any psychotherapy sessions or review medical records. I base my assessment off of staff report of the use of effective clinical interventions. All of the mental health staff I met with reported the use of at least some effective clinical elements of treatment: Exposure for social anxiety (Green Hill; Echo Glen), cognitive-behavioral therapy for trauma (Echo Glen), cognitive behavioral therapy for depression (Echo Glen), Cognitive Behavioral Intervention for Trauma in Schools (Naselle, Echo Glen). Apart from the psychiatry fellows rotating through Echo Glen, it was not

clear what level of training the mental health treatment providers had or were receiving to stay up to date with best practices. Mental health treatment at Echo Glen is highly specialized with youth receiving only trauma-focused treatment from the staff psychologist and other treatment needs (e.g., anxiety, depression, eating) were referred to the psychiatry residents. At Green Hill and Naselle, all types of psychosocial treatment were delivered by one staff member (both master level clinicians) who needed to be able to address a wide range of presenting needs. Variation in how mental health treatment occurs in the sites also reflects a lack of shared clinical oversight. Individual treatment in Naselle is typically short term (5 sessions) while treatment for trauma focused CBT is the standard length required by the curriculum (about 12 weeks), and all other mental health treatment at Echo Glen and Green Hill is at the youth's discretion and can occur throughout their entire stay.

While all of the mental health treatment providers were clearly motivated, compassionate and conscientious, they also all reflected on the inadequacy of the system (lack of sufficient staff, high complexity of needs) for delivering high quality mental health treatment. Neither approach (short term or through the entire term) appeared to be guided by symptom reduction (with the exception of TF-CBT which could be extended if youth symptoms were not resolving). Rather, much of long term treatment appear to be focused on providing ongoing, supportive care rather than targeted symptom reduction. Many youth appear motivated to engage in this type of therapy (i.e., more integrative therapy in which youth are focused on understanding and processing past trauma and formative events) and find it helpful. However, the evidence base suggests that shorter term, more symptom focused and directive treatments are often superior to less directive treatment in reducing symptoms.

It is also complicated to set symptom reduction as a criterion for delivering high quality care for JR in that being incarcerated is an active stressor and the interviews revealed that many youth are seeking guidance for how to cope with being in the facility and experiencing anxiety about what to do upon release. It could be that release from incarceration would be the fastest way to support symptom reduction for a number of youth. Barring this, general coping with active stressors could be addressed more manageably through group therapy focused on addressing common stressors of incarceration, and common fears about release. Ideally, this would continue to be facilitated by trained mental health providers in order to weave effective clinical skills into the group sessions. This could free up time for therapists to be focusing on one on one treatment for youth who have symptoms that are actively impacting their ability to function within the institution. Another complicating factor for recommending treatment within institutions is that the most effective treatments for complex mental health needs (ADHD, Autism/DD, Bipolar, psychosis) involve coaching individuals in the youth's immediate environment (family, schools) to promote more positive adaptation and functioning. Consequently, gains achieved during residential stay may not transfer with the youth to environments outside of the facility where families and schools would then need to be engaged into treatment to sustain improvements.

### *How well is JR implementing this treatment*

**Mixed.** The only treatment well-specified enough to evaluate for implementation is TF-CBT and, in this case, appears to be well-implemented with a highly qualified treatment provider (Echo Glen) who is actively engaged in the trauma treatment community. Otherwise, treatment

occurring in the institutions and being accessed in the community by youth in the community group home is not well-specified enough to evaluate.

*Are youth receiving the appropriate dosage?*

**Unable to Assess.** As there is no uniform reporting system for youth mental health outcomes through repeated measurement of symptoms, there is no way to robustly assess whether youth are receiving the appropriate dosage of treatment. The report of current practices suggests, however, that youth are likely either receiving not enough or more than necessary.

*Do staff receive the correct type and amount of training?*

**Not Acceptable.** Mental health therapists serving youth in the JR institutions are not being routinely trained in best practice clinical treatment standards. The fellowship rotation at Echo Glen ensures a number of youth have access to treatment by residents who are being exposed to evidence-based treatment strategies through other rotations but training for JR therapists is otherwise limited to what the clinician was trained to do prior to hire and whatever clinical strategies they are motivated to learn more about as part of their ongoing clinical education. The treatment approach is generally eclectic and therapist are being called upon to address a very wide range of needs without adequate training and consultation support.

*How well is the treatment integrated with the assessments, other treatments, and reentry planning?*

**Acceptable.** A strength of mental health treatment across all institutions is the effort to coordinate the medical and psychosocial treatment of mental health needs through team-based planning and ongoing coordination. Treatment plans are reviewed with mental health therapists, coordinators, psychiatrists and medical directors in the three institutions. Mental health service coordination between institutions and in the community when youth transfer is a significant focus but challenged by the lack of appropriate treatment in the community and disruptions in the continuity of treatment. A notable achievement is the system-wide focus on reactivating Medicaid eligibility for youth leaving JR care and working with local wraparound (WISe) teams in the community to support reentry. Many of the challenges of service coordination require coordination with systems outside of JR control but still present opportunities for JR to reconsider some clinical and coordination strategies. A critical area of need is ensuring continuity of care during transfers to different facilities within JR and during community release. Institution mental health therapists raised concerns about youth who are transferred to group homes no feasible way to continue care. Telemedicine facilities are inadequate, largely because offices with video chat functionality are also administrative offices that youth cannot be left in unsupervised. The group home that was part of this interview (Woodinville) went to significant lengths to ensure youth with mental health needs were connected with local community providers but the quality of these providers varies widely and the group home does not have control over the quality and availability of treatment. As outlined in more detail in the Woodinville summary, this has led to seriously concerning misdiagnoses and medication changes that resulted in youth being sent back to institutions for stabilization. A serious concern for reentry is the lack of follow up regarding whether a youth reenrolled in Medicaid, connected

to local a mental health provider through a WISe team or individual provider and whether a youth obtained prescribed medication. This is another way that being committed to JR can actively worsen mental health status as eligibility for Medicaid is terminated once a youth is committed and they must reenroll or have benefits unsuspended in order to continue to receive services at release. If this does not go smoothly, youth are returned to community with fewer medical resources than they had before commitment, particularly if they were receiving mental health services prior to sentencing.

*Does the current quality assurance plan adequately measure the treatment model?*

**Not Acceptable.** Quality assurance support for mental health treatment at JR appears to be primarily focused on strategies for initial mental health assessment, service coordination and for the milieu treatment (integrated treatment model) that was not part of this review. There did not appear to be a quality assurance plan for monitoring the treatment of specific mental health disorders.

*Do you see any evidence that would concern you that treatment access varies by race, ethnicity, age, or gender?*

**Mixed.** I did not see any evidence that treatment was not systematically offered to youth on the basis of demographic status with one exception, substance abuse services are provided in a cottage unit at Echo Glen that is male-only. However, I also did not see evidence that mental health treatment was explicitly mindful of race/ethnicity and cultural considerations in training being provided to therapists or in models being used in treatment. For example, racism is increasingly being recognized as a stressor that can heighten symptoms of trauma and using culturally-grounded metaphors and cultural traditions to adapt treatment can engage better buy in and treatment outcomes. This would be extraordinarily difficult for the individual therapists to manage adequately on their own, along with being expected to treat such a wide array of mental health needs.

*What recommendations do you have to improve implementation given the current level of resources?*

Many of my recommendations are embedded in my comments above and I summarize them here in order of priority based on what I think would best support youth mental health stabilization and long term functioning:

**1. Restructure the delivery of mental health treatment** to provide more stepped care approaches beginning with group-based treatment facilitated by mental health staff using evidence-informed curricula for treating anxiety, depression, trauma, and social skills (particularly for youth with ADHD, not just focused on anger management principles) and then moving to one on one treatment for youth who continue to display consistent and concerning behaviors (self harm, externalizing). Use an electronic platform for measurement-based care during individual treatment to track specific behavioral targets and use clinical supervision to adjust clinical approaches as needed. Ensure youth have access to general, non-clinical social support resources (e.g., coaching) for reinforcing and maintaining good problem-solving skills,

positive self-identity, within the cottages but do not expect line staff to deliver sophisticated clinical models. Adopt standard treatment guidelines for use across all facilities and consider using mental health coordinators as liaisons to educate and encourage the use of these curricula in community treatment clinics in areas surrounding group homes (e.g., co-training).

**2. Improve clinical** continuity by either a) involving regional mental health coordinators from the youth's home community in their treatment planning immediately after placement and have the coordinators act as advocates/monitors for quality and continuity of care throughout the youth's various placement transfers and reentry to community; or b) improve telemedicine facilities and consider other ways to leverage mobile health or digital platforms so that youth can connect with institution mental health treatment providers to avoid gaps in care as youth are enrolling in community services.

**3. Ensure mental health treatment plans and targets of therapy are integrated** in milieu behavioral goals and planning by adapting current family system models to work with line staff in cottages and units. Expand the use of family-based interventions for youth at reentry (e.g., the work that will occur with the NIMH grant under the supervision of Dr. Ahrens and Ted Ryle). As much as possible, look for ways to support local communities to deliver these models instead of institutional placement through Option B or other sentencing alternatives, particularly for younger youth and those with autism, ADHD, developmental delays and learning disabilities.

*What additional resources would you recommend to improve treatment quality and integration?*

Mental health treatment staff capacity needs to be expanded but it should be done in concert with some restructuring of services, e.g., more stepped care approaches, in order to ensure services are effective and efficient. Mental health clinical quality oversight needs to be instituted with more resources invested in cross-site training and clinically-oriented supervision/consultation on cases. JR cannot ensure the continuity of care in reentry alone. The mental health and child welfare systems need to coordinate to adequately fund transition services. An urgent need is a position to monitor the mental health service continuity of all youth at reentry to ensure Medicaid enrollment, service enrollment and economic/housing stability (note: the hiring of a housing navigator occurred shortly after my site interviews) and to support the quality of service at the community level.

*JR will be serving youth up to age 25 in the future. What advice would you give the agency as they prepare to provide this treatment for older youth?*

In many ways, institutional placement can more effectively accommodate the treatment of adult mental health needs than youth mental health needs. Mental health treatment staff should be trained in the developmental tasks of emerging adulthood and brain development. They should be provided with more information on prodromal and first episode psychosis identification and treatment strategies. Substance misuse is likely to be an even more predominant issue and treatment for SUD will likely to need to expand. Reentry services will need to focus even more on housing and employment and in the case of youth adults with serious mental illness, should use evidence-based approaches (e.g., supportive employment).

*Please provide a statement of qualifications*

I have a PhD In Counseling Psychology from the University of Southern California, a clinical degree for which I was trained to competently deliver psychological assessments and psychotherapy for a range of mental health disorders. I currently direct a research and policy center that serves as a resource to Washington State on the use of effective clinical treatments for child and youth mental health (Evidence-Based Practice Institute). I have fifteen years of experience as a researcher and program developer in the area of youth behavioral health. My evaluation and recommendations in this report are my own and in no way represent the views of my employer (University of Washington).

# Woodinville Group Home

The Woodinville Group Home is a 15 bed, step down facility for youth transitioning from larger institutions to release. It is a minimum security facility and youth must abide by the facility rules and expectations in order to remain at the placement. Youth at Woodinville are expected to engage in school and/or employment programs. The facility maintains work relationships with surrounding businesses. The group home is not equipped to internally manage mental health treatment; however, a high percentage of youth sent to the facility have some level of mental health need. Most often this includes medication management but may also include the need for psychosocial treatment.

The interviews informing this summary were conducted in person with the facility Director and Mental Health Regional Coordinator. Mental health services are coordinated with external service providers. Providers not included in the interview include Ryther, a multiservice behavioral health agency in northeast Seattle; Healthpoint, a Federally Quality Healthcare Center that is a relatively newer service provider for Woodinville; Valley Cities, a community mental health center; and Northshore for substance dependence treatment. Woodinville youth are additionally connected to Wraparound with Intensive Services (WISe) community mental health providers as part of release planning.

## Assessment

Youth mental health needs are typically identified through the transition packet provided by the institution as part of release planning. The packet includes mental health assessment reports and notes any previous and current prescription medications and previous psychiatric inpatient stays (CLIP or Seattle Children's facilities, typically). In addition, facility staff may reach out directly through email or a phone call to discuss the youth's case and needs prior to transfer. The interviewees noted that the Naselle is the most consistent in providing this information. The interviewees noted the Sexual Aggressive and Vulnerability Youth (SAVY) and Suicide and Self Screen (SSS) are included in the packet of youth information. This packet of information is forwarded to the youth's prospective case manager in the group home. Either the director or the case manager may speak to the transferring facility to discuss additional, sensitive information. The interviewees noted that Naselle is also good at discussing the WISe program with youth before transition.

In addition to the group home review, the regional mental health coordinator maintains a list of all youth with identified mental health needs transferring to JR regions 3 and 4, which includes the Woodinville group home. She obtains mental health information from the Initial Client Information (ICI) form and the WISe eligibility tool to determine which youth follow. If a youth is placed at Echo Glen prior to transfer, the mental health coordinator and a representative from Healthcare Authority, the state agency overseeing WISe implementation, will visit the youth to discuss the program. The coordinator also sits on two regional governance teams for mental health administration, the FSPYRT north and south.

# Treatment

While the regional mental health coordinator is a significant resource for youth on parole who are also eligible for WISe, this leaves youth with mental health not on parole underserved. Further, less than half (about 40%) of youth eligible for WISe agree to enroll and, of these, only about 20% will follow up with services. One of the challenges is that the local WISe programs must reach out to screen and engage youth who are eligible. Some WISe programs are willing to meet or call you prior to release, but capacity varies by site.

Woodinville has a long term treatment partnership with Ryther and, specifically, with Ryther's adolescent psychiatrist. The interviewees felt youth are able to receive high quality mental health care at Ryther because of the staff's expertise and familiarity with the needs of Woodinville's youth, including expertise in Dialectical Behavioral Therapy. In years past, Ryther would send mental health staff to the facility to conduct assessments and provide treatment but declining population at the group home make these trips inefficient for Ryther. Now the group home staff drive youth for appointments. Ryther is about 15 miles away from the facility and transporting and waiting for youth can take about 3 hours of a group home staff member's time. Because of the travel and waitlist, Woodinville is exploring other treatment partnerships that are closer or may be able to see youth more quickly. Other agencies include Bothell Health point, Valley Cities and Northshore for substance use treatment.

Communication to Woodinville staff from treatment providers varies by agency. At Valley Cities, the counselor will speak to the group home case manager after the session. Ryther general sends a post-session generic report regarding medication dosage and treatment plan. Behavioral Health Point will also send a treatment plan report. Interviewees generally felt that the connection between treatment and group goals were weak. Each youth is assigned a case manager within the group home who meets with the youth at least weekly to review the youth's progress towards goals and support school and employment success. Facilities vary in their ability to match youth with a preferred provider based on gender or race. Interviewees reported that, at the time of the interviews, their perception was that all of the therapists at Northshore were Caucasian.

Youth with unmet mental health needs impact the social climate at the group home, particularly youth who are opting to not take prescribed medication. Occasionally, these youth will return to a larger facility where there are more supports for complex needs. A more common or difficult treatment change is drug/alcohol use. Youth will report that they received treatment at a larger facility but will still come to the group home with dependence and may have been using while in the larger institution. A drug and alcohol counselor from Northshore comes to the facility to conduct groups and provide individual counseling but Woodinville staff felt that this was not sufficient for some youth. Youth involved in both mental health and substance use treatment may get up to three hours of treatment a week. About 60-75% of youth come to the facility with a substance use problem. Marijuana, methamphetamine and alcohol are the most commonly used substances. The facility does not get as many youth with opioid addiction although they do occasionally and will have Narcan available for use. Therapeutic Health Services (THS) is the local provider who can administer Vivitrol if needed.

# **Characteristics of youth**

The most common mental health symptoms for youth at Woodinville are sleep dysregulation, attention span and functioning outside of the facility at school or work. The employer may report that the youth is unmotivated or refuses to participate in certain activities. There are not many incidences of reactivity or aggression. The most common diagnoses are anxiety, depression, PTSD (which is increasing in prevalence) and occasionally psychosis.

The youngest youth in the group home is 16 and most clients are 18-20. Older youth and young adults typically have long sentences and the system is eager to have these youth move into group homes to have a more real life experience. Housing after release is a significant issue as most of the youth are adults and not planning to return to live with family. A housing coordinator for all of JR is expected to be hired within the next year but current resources are limited to supporting these transitions.

# **Recommendations**

The interviewees identified some suggestions for improving current treatment and coordination of mental health services. These included system level coordination and communication with more time dedicated to regional staff communication about clients' mental health needs, transitions and treatment. Suggestions also included having the mental health coordinator and other external support staff join reentry team meetings to encourage youth engagement with mental health services after release. Woodinville staff felt they could begin implementing this immediately with no additional resources required. The interview also identified the need for more resources dedicated to transporting youth to mental health appointments and/or developing better facilities for telemedicine. The group home has only had one youth participate in telemedicine with the referring state institution. In order to implement, an IT person would be needed for consultation and setting up a secure system. Finally, the interviewees noted the importance of hiring engaged, enthusiastic group home staff to support youth with medication and treatment compliance.

# **Echo Glen**

Echo Glen Children's Center is a medium/maximum security facility located approximately one hour east of Seattle. The population primarily includes young males, males with specific behavioral health treatment needs, and females. The facility maintains separate therapeutic units for males with substance use disorders and males charged with sex offenses. All youth at Echo Glen receive Dialectical Behavioral Therapy group sessions and Aggression Replacement Training group sessions.

The interviews informing this summary were conducted in person for 2.5 hours with the Staff Psychologist, the staff Psychiatrist and the Associate Superintendent. Additional written information was provided by Echo Glen's Medical Director/Adolescent Medicine physician. Other staff involved in mental health oversight for treatment include the Mental Health Coordinator, the JR Medical Director and the Health Center Administrator.

## **Assessment of mental health needs**

Mental health needs may first be detected in the medical assessment conducted by nursing staff within three hours of a youth's arrival to the facility. This includes an assessment of self-harm risk (Suicide Self Harm Scale). Within the first seven days of arriving at Echo Glen youth receive a mental health assessment from a licensed, clinical psychologist. The assessment includes the anxiety and depression subscales of the Beck Depression inventory, and the UCLA PTSD scales. This information is integrated with medical information obtained in the initial nursing screen. Within two weeks, youth also receive the Integrated Treatment Assessment (ITA), a comprehensive assessment that includes mental health history, use of psychiatric medication, risk for sexual victimization or aggression (SAVVY) and suicidal ideation. At the present time, the Beck and UCLA are not readministered prior to release but a new masters level practicum agreement may provide the capacity to complete these in the future. A youth will be referred for a psychiatric evaluation if they have an active prescription for psychiatric mediation, or may be referred if they have an eligible score on the SSS scale, significant disruptive behavior as reported by detention (or the transferring institution), are referred from the general adolescent medicine physician, cottage staff concerned about active mental health symptoms, or are self-referred.

Youth identified as having a mental health need through any of these pathways will have their case discussed at the weekly Mental Health Assessment Team (MHAT) meeting. The MHAT meeting includes the attending psychiatrist, nursing staff, the staff psychologist, a facility administrator, cottage program managers, and the mental health coordinator. Typically, the psychologist has met with the youth, administered the mental health assessment and conducted a clinical interview in time for the MHAT meeting immediately following a youth's arrival. Youth can also be referred for a mental health assessment at any time during their stay.

# Treatment

Three different specialized mental health treatment pathways are available to youth: Medication management, general psychotherapy, and trauma-focused psychotherapy. Youth already on medication or requesting medication meet with an attending psychiatrist or a psychiatry resident or fellow for medication evaluation and follow up management. A psychiatrist aims to follow up within 30 days of referral but large caseloads lead to average wait times of 2 months. For psychotherapy referrals, average wait times are closer to 4 months. In both cases, youth referred to psychiatry/therapy stay in treatment until discharge (average of 8-10 months). Medication management is guided by best practice principles for minimizing the use of psychotropics.

Youth with treatment needs other than trauma will be referred to one of the psychiatry residents or fellows for individual therapy. Fellows rotate to Echo Glen from Seattle Children's Hospital and are typically trained to deliver cognitive behavioral therapy for depression and generalized anxiety, exposure for social anxiety and dialectical behavior therapy for suicide and emotional dysregulation. As noted by the facility psychiatrist, the complexity of diagnosis and mental health presentation is high and, in addition to psychotherapy, mental health staff are often frequently called to consult with the individual living units about how to support youth. The psychiatry residents are expected to routinely assess youth using validated mental health symptoms measures (PHQ-9 and GAD-7) to monitor treatment progress. Youth typically stay in active treatment throughout their time at Echo, leading to longer wait times for new cases.

Youth diagnosed with Post Traumatic Stress Disorder or Trauma Disorder NOS receive Trauma-Focused Cognitive Behavioral (TF-CBT) treatment from the staff psychologist. Trauma experiences are common among youth at Echo Glen; staff estimated that 100% of youth screened with the UCLA trauma screen since 2017 have reported at least one trauma experience and an average of six traumatic experiences. TFCBT treatment lasts 16 weeks to 20 weeks (for complex trauma) and the average length of treatment is 5 months. Treatment goals are centered on symptom reduction so that symptoms do not interfere with the youth's ability to function in the facility by reducing flashbacks, nightmares/sleep, depressive symptoms, and hyperarousal. Many youth need to transition from the facility to a group home or home before treatment is complete and some have to decide whether to step down to a less restrictive residential environment or continue treatment. Efforts to continue treatment via video links are difficult. Group homes in the community do not have secure rooms for videoconferencing so youth use administrator offices and sessions are often disrupted by people coming in and out of the room. When ongoing treatment with the psychologist is not viable or is predetermined to be brief because of an upcoming residential transition, the sessions focus on psychoeducation and coaching the youth to advocate for themselves with providers who may not have a trauma informed orientation. Interviewees noted that youth transfers may occur without consultation with the mental health therapists and may occur at times that are disruptive to treatment and result in youth adjustment problems in the new placement.

Echo Glen also offers gender affirming care and gender evaluations to support youth who are investigating gender transition or want to explore their gender identity through partnerships with Seattle Children's Adolescent Medicine and the Seattle Children's Gender Clinic. Many of the youth seeking psychiatric care at Echo also have gender presenting conditions. Treatment follows gender evaluation international guidelines and, if deemed appropriate, psychiatric staff (national experts in this field) together with adolescent medicine to write a letter to support to the medical staff for beginning gender affirming hormone treatment. The process is reviewed by both Echo Glen and JR medical directors.

Other specialized treatment is offered for substance use disorder and sex offender needs. The mental health staff are not directly involved in these programs but take referrals to provide treatment.

## Characteristics of Youth

The rate of mental health need is very high at Echo Glen. Staff interviewed estimate more than 75% of the youth are receiving psychotherapy and/or psychotropic medication. Although needs are as high as youth in residential psychiatric settings, youth at JR have generally had less previous mental health treatment when compared to the population in child psychiatric settings (e.g., Child Study and Treatment Center). The volume of need is a challenge for mental health staff with only one full time psychologist and rotating psychiatric trainees who can only take 1 to 2 TF-CBT therapy cases at a time. According to the interviews for this report, the lack of sufficient mental health staff leaves most youth waiting for treatment or, even when in treatment, insufficient consulting and crisis capacity to manage daily behavior challenges. In psychiatric care, psychologists are typically dedicated per living unit at a ratio of about 10:1 and Echo does not meet this ratio with an ADP of 85 and one full time psychologist. Cottage staff burnout was reported as an issue with high turnover and insufficient training for supporting the institutional therapeutic model (DBT). Interviewees report that when Dialectical Behavior Therapy is happening consistently at the living unit level, one on one treatment can progress more quickly. As noted, keeping line staff competent to deliver DBT is a significant challenge. Interviewees for this report were consistent in noting problems with current implementation and that more staffing resources would be needed to support quality.

Despite the challenges of meeting needs, interviewees felt that ensuring youth receive adequate treatment when transitioning out of Echo to be a similar or an even greater challenge. Providers in community or group home settings may be less likely to be trained in trauma and evidence-based interventions for anxiety and depression or youth may be in the middle of medication change or trauma work when transferred. As noted, telehealth in the JR system is very challenging due to inadequate facilities in group homes. Further, the interviewees felt that communication about mental health needs when a youth is transferred to a community facility is generally poor. For example, one youth was in the middle of doing a cross taper of psychiatric medication when approached about transferring to a group home. The youth decided to go to the group home rather than finish the medication tapering with Echo. The Echo psychiatrist called the group home to discuss changes in medication but when the youth was taken to a local healthcare center, the youth was seen by a mental health professional not licensed to prescribe. The provider said the youth was no longer symptomatic and did not refer to a physician/prescriber. The group home then followed up with the Echo Glen psychiatrist because the youth had become hypomanic. The perception from the Echo Glen mental health staff is that community accessibility to high quality treatment is inconsistent.

For youth being released, interviewees felt that the majority would qualify for WISe but are not referred to the program. Wraparound with Intensive Services (WISe) is a care coordination model available to youth with serious mental health needs and is administered out of the public mental health system. Youth must be referred and assessed in order to qualify for services. One challenge noted in the interviews is that some youth have been rejected from WISe eligibility for not having a permanent address at release. The challenges in transferring youth between facilities and after release leaves many youth without sufficient mental health care for months.

## **Room confinement policy**

Echo is currently reviewing their room confinement procedures based on performance based standards and from administration. Some staff have concerns about whether youth who are actively unsafe need to be out of their rooms given the lack of staffing support for managing these cases. But, overall, interviewees felt that Echo's policies around room confinement are already ahead of other facilities and confinement is minimal and infrequent.

# Green Hill

Green Hill School is a medium/maximum security facility for older, male youth and is located in Chehalis, about 30 minutes south of Olympia. The facility is notable for housing a number of youth with a history of gang involvement. Green Hill is the only facility to have a contained mental health unit in addition to mental health treatment available to all residents. The counseling and treatment options are otherwise similar to the other facilities with one onsite mental health counselor, an onsite psychiatrist, an onsite mental health coordinator and an intake specialist.

Information for this report was gathered from in person interviews with the GH Psychology Associate (also referred to as the mental health counselor), the Mental Health Coordinator and the staff Psychiatrist. The Psychology Associate is a licensed mental health counselor (7 years) and is responsible for conducting assessments and providing mental health treatment. The Mental Health Coordinator assists with intake assessment for transferred residents, completing the violence risk assessment (SAVY) and gender expression assessment (SOGIE). The Intake Specialist conducts these assessments along with the GAIN-SS and the Suicide Severity Screen (SSS) as part of the initial client information report for new residents (new commitments).

## Assessment

Mental health assessment occurs within seven days of a youth's arrival to the facility and includes the Beck Depression and Anxiety Inventory (BDI) and the UCLA trauma screen. If a youth scores above the clinical threshold, indicating their need for treatment, they are reassessed within 1-3 months to gauge ongoing need and progress. The cut off threshold is calculated by the electronic health record system to produce a mental health acuity score. The BDI is also readministered within 30 days of a youth's release from the institution.

Youth are identified as needing a treatment from a variety of sources: mental health assessment, staff referral, parents/guardians request, and youth will also self-refer, often to request sleeping medication. In contrast to referral, some parents disagree with the need for the mental health treatment. According to the interviewees, about five times a year a parent will request that their child stop receiving medication and/or mental health intervention.

## Treatment

Youth in treatment receive routine medication management appointments with the psychiatrist and the mental health counselor for ongoing psychotherapy. Nurses keep the mental health counselor and psychiatrist apprised if youth refuse medication. Typically, noncompliance is due to the youth feeling too tired, feeling that the medication doesn't work or because the youth sells the medication (this most commonly happens with stimulants for ADHD or with Wellbutrin).

Psychotherapy is eclectic with a focus on cognitive behavioral therapy. If a youth has a severe anxiety issue, the mental health counselor may use cue exposure (e.g., for social anxiety). Anxiety often relates to the youth's concerns about what will happen to them after release, their future, or how to manage their time while incarcerated. PTSD is a common presenting treatment need. Youth will present with being afraid to sleep because of the severity of their nightmares. Less frequently, youth will present with psychotic symptoms or self-harming behavior. The frontline treatment in the institution for more severe psychiatric needs is medication followed by supportive counseling. For example, in a self-harming case, a youth was swallowing glass and switching the youth to Lithium stopped the behavior.

As noted by the counselor, treatment goals are typically focused on creating pathways for the youth's positive development. Depending on the youth's length of stay, sessions focus on supporting a youth's successful reentry into the community or the youth's ability to cope within the facility. Length of treatment depends on the youth's interest in continuing to engage in treatment and often last the entire length of stay. The counselor also worked with a small number of families to support a youth's treatment, particularly as these youth prepared for release. These sessions focus on developing plans for reinforcing youth positive behaviors and managing mental health needs. The mental health counselor noted that these were helpful but the facility does not have the capacity to do this work for each youth.

The mental health counselor and psych associate also provides consultation to line case management/counselor staff. The line counselor staff are expected to meet with youth routinely to offer counseling focused on the use of DBT skills, problem-solving and coping within the facility. Counselors may have masters degrees but more often have BAs or AAs and becoming a counselor is considered a promotion from a security level position. Counselors run unit level DBT groups.

Youth with acute mental health needs and lower social functioning may be placed in the specialized mental health unit (Baker). Oftentimes, the determining factor for whether a youth is placed is concern for their safety in the general population. Youth with mental health needs that have more aggressive behaviors may be placed in a different mental health unit (Cypress). The mental health units have more scheduled group treatment time and the line staff/case managers are generally more experienced and motivated to be delivering the Dialectal Behavioral Therapy (DBT) components than in other units according to interviewees.

## Transitions

Transition support from the facility to community focuses on enrolling youth in Medicaid and Wraparound with Intensive Services (WISE). The mental health coordinator works with the Health Care Authority to ensure the youth is Medicaid enrolled. Typically, HCA will tell the youth what health plan they are on rather than engaging with the youth to have a discussion about the best healthcare option for their needs. The Green Hill youth committee has a goal to support better decision making around health plan enrollment but the effort is not well coordinated with the mental health coordinator and HCA enrollment process. Currently, SeaMar staff meet or have a brief phone call with the youth to confirm the youth's address and then will assign the youth to a plan.

A youth is given their Medicaid number (Provider One) in their personal belongings at release. The Healthcare Authority is expected to unsuspend the youth's coverage on their release date in order to trigger the release of the youth's insurance card in the mail. The staff at Green Hill have no way to tell whether this is routinely happening and only hear about cases where it has not happened (for example, if

the HCA staff responsible for unsuspending coverage was on vacation). It was not clear to the mental health staff interviewed how consistently parole ensures that youth are enrolled in Medicaid or engaging in WISE teams. Oftentimes youth do not have phones and are only in contact with JR after release when they attend parole meetings. Conversations about a youth's interest in engaging in WISE occurs 60-90 days prior to release. If a youth is interested, Green Hill mental health staff work with the regional mental health coordinators to identify a local provider. The local provider conducts the eligibility screen (CANS assessment) with the youth. Only a handful of CANS screens have been performed for Green Hill youth. The impression from Green Hill staff is that youth do not typically follow up with local WISE services.

## **Characteristics of youth and treatment**

Staff interviewed noted that mental health counseling is helpful when delivered but capacity is not sufficient to address the volume of mental health need that line counselors are not consistently implementing the expected DBT skills. Further, transitions in care after release are difficult due to the need to rely on HCA and community providers for follow up. There is concern about the appropriateness of using line counselors to manage youth privileges and consequences as well as deliver effective counseling. The impression from the interviewees was that many counselors are not interested or do not feel capable to deliver DBT but because being a counselor is a promotion over security level staff, many pursue the additional certification. There was also concern that DBT may not be the best fit for a number of the general population youth who may need less specialized support and more focus on general problem-solving and coping skills.

## **Room confinement**

According to interviewees, room confinement at Green Hill is expected to be minimal. Fifteen minute "time outs" are used fairly frequently for youth who do not stop behaviors after being approached. Green Hill has a quiet room, a cell with a camera that may be used when youth behaviors are particularly aggressive.

# Naselle Youth Camp

Naselle Youth Camp is a medium security facility for males aged 16-21. The camp is located in the southwest area of Washington State approximately 2.5 hours from Olympia, WA. It is considered a general facility not equipped to manage acute mental health needs. Youth at Naselle have the opportunity to earn high school and general equivalency diplomas (GED), forestry work training in collaboration with the Department of Natural Resources or aquaculture training in collaboration with the Department of Wildlife. Youth generally stay in the facility less than one year.

The interviews informing this summary were conducted over the phone for two hours with the Associate Superintendent and the Mental Health Coordinator on 11/19/2019 and with the Psychology Associate, licensed MSW on 11/23/2019. The facility's licensed Psychologist resigned and Naselle is currently soliciting applications for her replacement. The geographical isolation of the camp is attributing to low recruitment success. Other staff involved in mental health oversight or treatment not interviewed include the general physician for Naselle and Juvenile Rehabilitation medical director; the facility RN who participates in mental health triage planning; and a contracted ANRP who provides psychiatric consultation and prescribes medication.

## Assessment of mental health needs

Naselle staff first become aware a youth has or may have a mental health need through the intake report provided by JR diagnostic coordinators stationed in regions throughout the state. Diagnostic coordinators conduct assessments prior to the youth arriving at a JR facility, most often these are conducted while the youth is still housed in their local juvenile detention center. The assessment contains quantitative items that flag for mental health need including whether the youth is currently or was previously prescribed psychiatric medication, previous hospitalization for a mental health need; and is currently or was previously receiving mental health counseling. In addition, the process accounts for presenting or history of self-harm or suicide ideation, or behaviors, as well a current endorsement of psychosis. Naselle may also get information directly from the detention center, particularly if the youth was disruptive and had a difficult time behaviorally adjusting to their detention stay.

When a youth arrives at Naselle, they undergo further screening for suicide and self-harm (Suicide Self Harm Scale, SSS), behavioral health needs (GAIN-SS), trauma history (UCLA trauma screen), depression and anxiety (Beck Depression Inventory, BDI), a medical screen for physical detoxing symptoms, educational assessment, substance use assessment, records review and requests for further information from families, home schools or community-based sources as needed.

# Treatment planning

Treatment planning is incorporated into Mental Health Triage meetings and reentry planning meetings (RTM) beginning within the first two weeks of arrival (pre-RTM meeting), the standard 28 day RTM meeting, and final RTM prior to release. Indications that a youth may have an active mental health need from any of these screens and informant interviews results in a youth's placement on the "Active Psych Referral List" and a discussion of mental health needs at the pre-RTM meeting. This list is an internal tracking document that identifies a youth in need of additional mental health screening/assessment and/or consultation, and prompts a meeting with the psych associate during which the youth can discuss symptoms they're experiencing and any history of interventions. Youth who potentially have an indicated treatment need beyond behavioral-based interventions and supported by objective information, are brought to a Mental Health Triage meeting involving the multidisciplinary healthcare team, which may consist of the mental health coordinator, the psych associate, the contracted ARNP, the onsite RN and the JR medical director (also the facility's Medical Doctor).

The Mental Health Triage team discusses the youth preferences for treatment, often related to medications they are currently on, would like to get off or would like to start. A common youth request for medication is to assist with sleep and may identify a specific medication as part of the request. If a youth requests sleep medication, the team will recommend a sleep study. For all requests for mental health treatment, the Mental Health Triage team discusses whether to start with behavioral protocols or medication; occasionally, behavioral interventions have been exercised without noticeable improvement, resulting in discussion about medication treatment. More recently, Naselle has received a higher proportion of youth with acute mental health needs than past years as will be described in more detail below.

# Treatment

Naselle provides three levels of treatment. For youth prescribed psychiatric medications, the contracted ARNP delivers consultation to clients up to three times a month. Delivery of service occurs in-person and through use of Telemedicine (video conferencing). When Telemedicine is used, youth meet in a private area in the facility over a secure video connection.

The psych associate provides brief (typically 5 session) psychotherapy for youth indicating a willingness to work on a particular issue (e.g. trauma).

The facility also provides a trauma group, facilitated by the psycho associate, that blends components of T-4, Cognitive Behavioral Intervention for Trauma in Schools (CBITS) & Adverse Childhood Experiences (ACE) materials into the overall group cycle. Residents emerge better able to identify trauma responses & are encouraged to pair these with evidenced-based interventions. In previous years, Naselle offered SafeDates, an interpersonal violence prevention program.

All youth, regardless of mental health need, are assigned a case manager who works with the youth on goals related to emotional regulation skills throughout their time at Naselle using the Integrated Treatment Model and Dialectical Behavior Therapy (DBT) principles. This includes

using behavior chains to help youth understand what motivates their behavior and coaching youth on various emotional and social skills. Naselle staff reported that the use of the ITM/DBT skills varies widely by staff member, largely due to gaps in training and tenure.

#### *Characteristics of youth at Naselle*

Naselle is not considered an acute mental health facility. However, staff reported that a high percentage of youth are coming into the facility with previous or active substance misuse (>80%), depression or anxiety. Naselle is not equipped to receive youth who have acute, untreated psychosis or are actively suicidal; initial placement for these youth would typically be either Green Hill or Echo Glen, where additional resources are available to address these issues. However, some youth do not manifest these needs or symptoms until after they are placed at Naselle and no formal mechanisms are in place to have these youth transferred to a different site. Currently, JR diagnostic coordinators conduct the intake assessment and the algorithm programmed into the computer system recommends a placement. The coordinator is able to intervene with central JR if they feel the assessment recommendation is not the best fit. However, if youth are transferred to Naselle and subsequently exhibit or report significant mental health needs, there is no process in place to review the initial placement decision and consider an alternative placement.

The staff believe that some youth who would historically be placed at Green Hill for mental health needs are being sent to Naselle, and the staff anticipates that this will become more common as facilities transition to serving youth up to age 25. Naselle staff do not currently have training in how to effectively interact with youth with severe cognitive delays, autism spectrum disorders or comorbid diagnoses (e.g., substance misuse/dependence, mental health and cognitive/neurodiversity needs). They are putting more youth on suicide precautionary level than in the recent past (>1 year ago). Naselle staff feel that the staff to youth ratio is too high for adequately treating youth with mental health needs in a milieu setting (smallest unit is 20 youth). This results in a lack of integration between a youth's mental health treatment goals and how the youth is managed within their unit. The emphasis of the facility is safety, psychiatric medication management, communicating on a youth's progress during team meetings and communicating information to community or group home providers prior to transition. Case managers assigned to work with youth on their general behavioral goals in the milieu have received limited training on how to evaluate how mental health needs are intersecting with self-harm and aggression.

## **Room Confinement**

Youth are confined to their room for physical aggression and defiance towards staff. Youth stay in their rooms until they demonstrate emotional stability and make a verbal commitment follow program expectations to and act safely. A high number of cases (80% estimate) are out of confinement status as soon as they can verbalize a commitment and no longer present as a safety risk to the milieu. Some kids may have been in a bad fight and go in at 6pm that night and not out until 10am next morning; this accounts for a minimal percentage of all confinements. Youth are out of rooms programmatically more than they ever have been (vs. in room programming). Residents may program in their rooms during brief (i.e. 30 minutes) periods to accommodate to staff shift changes and meetings, etc. Incident reports reflect staff's

efforts to coach and re-direct youth multiple times before send the youth to their room for a time out (up to 15 minutes) or longer (confinement status). Fights, assaults, destruction of property and, repeated failure to follow staff direction or program expectations are common incidents leading to placement on confinement status. While on room confinement youth are visually checked no less frequently than every 15 minutes at staggered (unpredictable) intervals. Weekly administrative, management and living unit team meetings review the use of room confinement while generating ideas and forming alternative interventions to reduce/replace use of confinement Interviewees viewed this policy as a work in progress with some concerns about the underlying assumptions, e.g., kid must be dysregulated to act out. With some kids willful, intentional behavior is not necessarily a product of dysregulation and the facility needs support developing and implementing alternative behavior modification plans if room confinement is not available.

**Appendix J:** Implementation Assessment of Suicide and Self-Harm Prevention  
by Dr. Linda A. Dimeff

## **Washington State Juvenile Rehabilitation Report Suicide Prevention**

**Report by:**  
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**Submitted:**  
March 20, 2020

## Executive Summary

Washington state Juvenile Rehabilitation (JR) has long been on the forefront of developing and implementing evidence-based behavioral practices for the care, management, and treatment of the youth it serves. This includes its inclusion of a comprehensive approach to assessing, managing, and treating youth who are at risk for death by suicide and/or engage in suicidal and/or non-suicidal self-harm behaviors. The overarching approach to suicide and self-harm prevention was developed in collaboration with national consultant, Lindsay M. Hayes, PhD in 2001. Prevalence and risk factor data have been subsequently updated by JR personnel. The Suicide and Self-Harm Screen (SSS) and protocol was developed in partnership with Andre Ivanoff, PhD from Columbia University. Dr. Ivanoff is a DBT expert who has devoted her career to helping disseminate DBT to complex, multi-diagnostic suicidal and self-harming persons. The intention of this review was to determine the extent to which the suicide and self-harm Policy 3.30 and associated procedures are fulfilled at JR and to make recommendations as needed. To make this determination, several JR site visits were made during November, 2019; subsequent telephone interviews were conducted in March, 2020. Whenever possible, conversations included a range of staff (leadership and frontline youth counselors), visiting the units, and speaking with youth.

## Key Findings:

- The Policy 3.30 that governs the procedural practice of assessing, managing, and treating suicidal and self-harming youth is comprehensive, sophisticated, and contains numerous safeguards to ensure each at-risk youth's situation is carefully assessed. Counselors conduct a comprehensive interview guided by a desk manual that includes well-formed scripts to help ensure that the questions are sensitively asked and that the youth is oriented to the direction of the interview. Staff are also required to document their own observations as well as relevant historical information and to determine the Safety Plan Level. All of this occurs in the context of an online electronic environment that ensures completion of each of the questions. The document is then electronically submitted to a Designated Suicide Prevention Specialist (DSPS), a person appointed by the medical director who has more elaborate training in suicide prevention. The DSPS can either approve or deny (override) the counselor's recommendation. The SSS is a dynamic tool that is used whenever there is a change detected in the youth's behavior/risk.
- All staff working with youth are required to complete multiple trainings on suicide and self-harm prevention. This includes an initial facility-based training within the first week of their employment to ensure that they understand the policies and procedures. Within the first several months of their employment, they are required to complete a comprehensive full-day (eight hour) training in suicide prevention. This training is very thorough, comprehensive, and is likely more than most licensed clinicians receive in graduate school. Brilliantly, employees are expected to study and memorize risk and protective factors *before* arriving at their training. In addition, they are expected to locate their Emergency Suicide Response Kit in their facility and observe an intake SSS. Each of the required assignments includes a worksheet the new employee uses to guide their experience. These training approaches are sophisticated and rigorous.

- The SSS is not really a screening tool, but is instead a fairly lengthy comprehensive assessment. All staff that I spoke with found the tool easy to administer and noted that it is reliably conducted in accordance with Policy 3.30. The DSPSs I spoke with found that it provided them with the information they needed to validate or reject the Suicide Prevention Level assigned by the counselor completing the interview. The majority I spoke with thought that the SSS contained redundancy and might be consolidated to reduce time to administer. On average, a typical youth might complete the SSS on four occasions, yet there is only one version that contains items that are unlikely to change. (Please see Appendix B, *Observations for the Suicide and Self-Harm Screening*). Additionally, the second part of the SSS contains redundancy with the first part.
- The vast majority highlighted how staff shortages and low staff retention significantly reduce the overall clinical quality of the SSS. A number of factors account for this fact: First, most newer staff are simply not sufficiently trained to conduct more than a simple, rudimentary SSS and treatment plan based on findings from the SSS. In this instance, the problem is one of lacking the capability because they are new and simply do not have the lived experience as a more veteran staff has. Second, even when a counselor has the capability, they simply do not have the time to do more than a cursory barebones assessment and treatment plan. This may be particularly true on units with high degrees of aggressive, assaultive behavior (more than the norm within JR) and where staff are “constantly putting out fires”.
- The policy does not allow for exceptions or for a DSPS to override the policy in certain circumstances which in some instances may have an iatrogenic effect. Concretely, there are youth who will use suicidal threats to avoid something they do not want to do, to get staff attention and time, and/or to cause disruption on the units when staff are already overwhelmed with staff shortages. When it is known that the behavior is solely for these reasons, following the policy simply reinforces/strengthens the very behavior the policy seeks to reduce. Those I spoke with who serve as DSPSs were mixed about how to solve this problem: while they universally preferred to have the capacity to deviate from the normative policy, unless it were codified in the policy and contained safeguards to guard against drift, they would be hesitant to change the policy.
- The treatment plan to address suicidal and non-suicidal self-injurious behavior requires sophisticated behavioral procedures that are contained within Dialectical Behavior Therapy (DBT). These include: behavioral chain analysis, solution analysis, commitment strategies, and strategic use of the diary card. Even under optimal circumstances, these therapeutic strategies are complex and difficult to do well without extensive training, supervision, and consultation that includes monitoring the counselor’s actual clinical capacity. (See DBT report). However, Washington State JR, despite a golden-years decade of learning and implementing DBT and other evidence-based behavioral therapies in the late 1990s, is not currently able to offer optimal circumstances. Staff shortages and staff turn-over have significantly compromised JR’s ability to train up its workforce in these and other procedures and to maintain whatever training gains it makes. Non-competitive wages make it particularly challenging to recruit personnel at all levels (AA, BA, MA, PhD). The situation is even more dire in rural areas. Without staff retention and comprehensive training, consultation, and supervision, it is difficult how counselors can be expected to actually *implement* an effective treatment plan that reduces suicide and self-harm risks. Blocking procedures and the SPL procedures will ensure that those

at risk in the moment do not have access to lethal means and methods to cause self-injury or death by suicide. This is different however than having a carefully developed treatment plan as specified in Policy 3.30 that will serve them well after they leave JR.

### Main Recommendations

- 1. Reduce Staff Shortage, Improve Retention.** For all organizations, the capacity to implement its vision hinges on its employees learning and doing the requisite tasks required to fulfill the vision. Staff shortages make it difficult for staff to attend trainings and have the required time to do what is required well. Additionally, staff turn-over results in a steady stream of beginners without building system competence.
- 2. Reduce SSS interview process.** There are a number of ways that the current SSS could be retooled to reduce redundancy, increase collaboration, and improve efficiency while remaining a gold-standard tool. Several suggestions are offered in the Appendix B. It is recommended that JR consider convening a task force comprised of all relevant stakeholders (including youth) and outside suicide experts to streamline the method. To ensure its integrity and excellence, the final version could be reviewed by a panel of adolescent/young adult suicide experts.
- 3. Ensure Adequacy of Training for DBT Core Competencies.** While the SSS Desk Guide provides scripts to read to conduct a thorough suicide/self-harm risk assessment, no such script is feasible for developing a youth-specific treatment plan let alone conduct the quality of treatment required by Policy 3.30. The only way a counselor will be able to actually treat that which he/she/they assessed using the SSS is by receiving comprehensive training in the treatment procedures, including ongoing consultation and supervision. Treating complex, multi-diagnostic youth (particularly those who do not want to engage in treatment) is not simple. The training is extensive, comprehensive, and ongoing. Without adequate training, supervision, and consultation that transfers to developing and executing a patient-specific treatment plan for treating suicidal/self-harm behavior, there is little reason to believe that we will reduce the youth's long-term suicide risk.
- 4. Carefully Consider Providing DSPP Option to Deviate from Standard Procedure.** The problem of youth stating they are suicidal in order to avoid something they do not want to do or get something they want is not an uncommon problem in juvenile justice facilities. Having a senior member of leadership have the capacity to override the policy when it is abundantly clear suicidal behavior is solely an operant behavior is wise. It is also wise that change to the policies and procedures are done mindfully and do not create another set of problems when solving one. One solution may be to create a special treatment plan for these youth that is reviewed and approved by two or three other DSPPs well in advance of the time that it will be needed – so that no such decisions are being made in the moment to deviate from the policy. This approach might also require two DSPPs to sign off on the permission to deviate in the moment.
- 5. Consider Having a Designated Suicide Expert Available for more Complex Cases and to Conduct Quality Assurance Review of SSS.** Given staff shortages and problematic staff retention, JR could benefit from having a QA process to cross check whether problems assessed in the SSS and behavioral chain analysis are being effectively treated using the most effective strategies.

## ASSESSMENT

**Materials Review.** In advance of visits and interviews at facilities, the JR Clinical Director provided numerous documents for my review. Each document is reviewed in Appendix B. When relevant, detailed observations for each are noted.

## OBSERVATION AND INTERVIEWS

Leadership staff and counselors were interviewed at **Green Hill School** (November 8, 2019 & November 12, 2019), **Naselle Youth Camp** (November 25, 2019), **Touchstone** (November 27, 2019), and **Echo Glen Children's Center** (November 27, 2019). Observations are detailed below.<sup>1</sup> Individual and group interviews with seven staff, the majority of whom were DSPS providers, were conducted during the week of March 9, 2020.

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<sup>1</sup> These observations focus specifically on those relevant to my assessment of the suicide/self-harm policies and procedures that have *not already* been detailed in the DBT report prepared by me for Washington State JR. Several observations noted in the DBT report are relevant to the quality suicide/self-harm assessment, management, and treatment. These include: the significant problem of staff shortage and high rates of staff turn-over that compromise JR's ability to have a workforce adequately trained to fulfill its clinical mandate and vision. I note in the DBT report that these factors result in uneven delivery of evidence-based behavioral interventions because only a few staff have the requisite core competencies to do the treatments.

## APPENDIX A: QUESTION INFORMING REPORT

Washington State JR provided the following questions for consideration during my visits and to guide the summary of my findings.

**1. Are youth being appropriately matched with treatment based on need?**

- a. What assessment is being used for program eligibility?
- b. Is the assessment being used appropriately?

*Policy 3.30 and its associated practice procedures provides a comprehensive framework for screening, managing, and treating suicidal and non-suicidal self-harm behaviors throughout all parts of the system. The primary tool used by Washington State JR (the Suicide and Self-Harm Screen; SSS) provides for three main levels of observation (SPL1, SPL2, and Observation Level) for those deemed at risk by virtue of a number of specific, observable and historic information. The level of intervention and oversight of youth is contingent on their level. The assessment is being used appropriately though some enhancements to the SSS process could help ensure that it is easier to administer -- and potentially more reliably administered. Please see recommendations.*

**2. Is the treatment high quality?**

*Staff shortages and staff turn-over, combined with limited comprehensive training and supervision, compromise the routine application of high-quality treatment. Many of the veteran staff have retired or moved on. Those that do have the capability do not often have the time. The quality of care a youth receives is highly variable – from a brand new clinician who provides garden variety therapy in response to the SSS (albeit with good intention) to some of the most talented clinicians in the country.*

- b. Are youth receiving the appropriate dosage? *Unlikely do to staff shortages, poor staff retention, and limited training. Also, in some cases, the appropriate treatment is no intervention in cases where it's fully operant behavior.*
- c. Do staff receive the correct type and amount of training? *In comparison to DBT training, it does seem that immediate training in assessing suicidal and self-harm behaviors occurs routinely. The quality of training is outstanding.*

*d. Does there seem to be variation by location? (between institutions, between institutions and community facilities) In units that have higher than usual levels of aggressive behavior and are larger, it is likely that the quality and availability of treatment varies.*

*Please see attached report.*

**3. How well is the treatment integrated with the assessments, other treatments, and reentry planning?**

*While the policy and practice procedures require thoughtful and ongoing screening, assessment, and management of suicidal and non-suicidal self-harm behaviors across the continuum, the ability of a counselor to do the requisite steps is contingent on receiving training, consultation, supervision, and ongoing support doing DBT. Currently, for example, the treatment of suicidal and self-harm behaviors is based on a counselor's capacity to: conduct a behavioral chain analysis, develop safety and stability strategies to use in the face of a crisis (solution analysis), gain a commitment to use skills rather than engage in suicidal and/or self-harm behaviors, and track/target it all on a diary card. Each of these tasks, including creating a treatment plan that addresses short term and long term risk, is complex and difficult to master, even for PhD level behavioral clinicians. It is hard to imagine given the extensive staff shortages and turn-over that the majority of counselors have the requisite skills to actually DO what's called for to fulfill Policy 3.30.*

**4. Does the current quality assurance plan adequately measure the treatment model? It does.**

**5. Do you see any evidence that would concern you that treatment access varies by race, ethnicity, age, or gender? No evidence.**

6. **What recommendations do you have to improve implementation given the current level of resources?** *Please see recommendations.*
7. **What additional resources would you recommend to improve treatment quality and integration?** *Please see recommendations and observations. The most significant suggestion is to streamline the SSS process. While called a screening, it is a fairly comprehensive interview that includes redundancy (asking repeatedly about distal/historic factors already known to JR).*
8. **JR will be serving youth up to age 25 in the future. What advice would you give the agency as they prepare to provide this treatment for older youth?** *To incorporate risk factors, protective factors and other risk and protective factors for older youth.*

## APPENDIX B: MATERIALS REVIEWED

**POLICY 3.30 & MEMO OF 9/27/2019 ENTITLED, “CHANGES TO SUICIDE PRECAUTION LEVEL (SPL) AND SUICIDE AND SELF-HARM SCREENING (SSS) POLICY AND PRACTICE.** The memo highlights changes to policy and practice based on feedback from auditors with the National Commission on Corrections Healthcare. An updated policy and practice for the Suicide Precaution Levels (SPL) and SSS was to be released on November 7, 2018: *SPL 1-3 combine into SPL1 and SPL2, and SPL4 changes to Observation Level.* Each level is described in the memo.

Several notable (to this reviewer) observations about the policy itself: First, the policy is comprehensive and contains best practices in the prevention and treatment of self-harm and suicidal behaviors. Elements focusing on suicide include: a clear expectation that all staff who work with youth are oriented to and trained in suicide/self-harm screening, intervention, and policy; training, testing, and supervision will be ongoing to ensure excellence of care; each facility has a quality improvement process to ensure the policies and procedures are being followed at all levels; each facility will have Designated Suicide Prevention Specialists (DSPS) who are appointed for their own internal expertise in suicide prevention precautions, screening, and treatment; that a designated response team is at the ready in the tragic event of a suicide. Elements focusing on non-suicidal self-harm behavior include detailed action for how to assess, track, and treat. These include: assessing self-harm behavior when it occurs using a behavioral chain analysis; identifying safety strategies to use for emotion regulation instead of engaging in self harm; getting commitment from the youth to not engage in self-harm; develop and update treatment plan that targets and treats self-harm; use and review of diary card.

**SUICIDE AND SELF-HARM SCREEN (SSS; BLANK FORM).** I reviewed a blank version (six-page document) of the SSS. This is a comprehensive form that includes a thorough assessment of current and proximal factors of risk for suicide and self-harm. The form includes a 21-item assessment with youth about current and historic factors (e.g., Currently using prescription medications? Have you been more anxious than usual? Have you ever had thoughts or urges to harm or kill yourself?). A Staff Observations/History 17-item assessment for completion by staff based on the known history and observations. Some items are repetitive, but consolidated (e.g., Has youth expressed or demonstrated: sadness, irritability, anxiousness, hopelessness, or despair?) as well as observational in nature: has youth demonstrated withdrawal? Upon completing the initial screening items, staff are required to select a recommended Suicide Precaution Level (SPL): Level I, Level II, Level III, Observational Level, or No Level. Consistent with JR policy, the SSS includes information about whether the parent was notified, the date of notification, and additional comments. Finally, SSS includes the approval status (Approved, Denied) by the Designated Suicide Prevention Specialist (DSPS).

### ***Observations:***

1. With a total of 21-items to ask/review with the youth and 17-items for later completion by the staff, this tool is more of an assessment device than it is a “screen”. It is length, repetitive (asking youth, then completing similar items in a section section), and requires additional comments (staff time) if an item is positively affirmed. While the intent of this assessment is to ensure all bases are thoroughly covered at all moments to reduce suicide and self-harm from occurring and ensure best care, it seems unnecessarily complex and redundant particularly in an already burdened system with significant staff shortages. Within healthcare contexts, screenings tend to be brief (a handful of items). If a person has screened positively, then a more comprehensive questionnaire is provided followed by a still more comprehensive assessment.

For example, National Institute of Mental Health researcher, Lisa Horowitz, PhD, MPH and her colleagues have recently published the [Ask Suicide-Screening Questions](#) (ASQ) screening method containing four screening items followed by a fifth ("Are you having thoughts of killing yourself right now?"). If yes, then the clinician moves to the next level of screening.

2. The same tool is used for historic/distal information (e.g., *"Has anyone in your family or close to you harmed or killed themselves?"*, *"Do you tend to do things impulsively or before think about them?"* as for proximal/immediate information (e.g., *"Have you been sadder than usual?"*, *"Have you had something bad or stressful happen to you lately?"*). It seems as if the same SSS is used for the initial assessment and throughout the youth's involvement as JR – thus making the items very redundant.
3. The Staff Observation/History items consolidate similar items and may provide a helpful method for streamlining questions for youth: *Has youth expressed or demonstrated: sadness, irritability, anxiousness, hopelessness, or despair?* If affirmed, then details are required. A similar approach could be taken to reduce the sheer volume of questions.
4. Some approaches for suicide assessment, like the *Collaborative Assessment and Management of Suicidality* (CAMS) approach are done in a fashion that helps build and establish rapport. The CAMS Suicide Status Interview (SSI) provides the structure to ensure completion of the task. Because the method is highly collaborative, it also engenders a building of rapport and creating of therapeutic alliance. In other words, the *process* itself is therapeutic. The SSS feels more like a research tool to gather information in an impartial, standardized, research-validated manner. Other documents strongly encourage users to not deviate from the specific questions as they are because the method is validated. The CAMS is just one method of how a suicide risk assessment can be delivered in a reliably and in a method that engenders compassion and discussion. Such an approach then might allow for only one section – with additional notes provided by counselor if they and the youth are in disagreement and/or if the counselor wish to make observations that they prefer to not discuss openly with the youth. (Therapeutically, even discussion of what they observe seems both clinically relevant and helpful).

**STUDY GUIDE FOR PREPARATION FOR INITIAL 8-HOUR FULL DAY SUICIDE PREVENTION TRAINING.** This nine-page document provides a high-level overview as well as tracking of content they are expected to do as preparation for the day-long training. A checklist of required preparation includes: watching "Teen Suicide" video; being prepared to recite suicide specific information about warning signs, risk factors, high risk periods, protective factors from memory; review of Policy 3.30, the SSS Desk Manual 2019, and Supervisor Conditions; locate and examine the Suicide Response Kit; and observe an Intake SSS. Staff and their supervisor are required to sign off on having completed these preparation tasks. To aid the trainee in actively engaging in the observation of the intake, a SSS Observation Sheet helps guide their awareness and learning of relevant domains and content. A Warning Signs, Risk Factors, High Risk Periods and Protective Factors document summarizes content to help learn the relevant content. The Suicide and Self-Harm Observation and Documentation Grid details the Level Placement Criteria, Observation, Documentation, Supervision Conditions, Reduction Timeframes, Required Mental Health Consultation for each of the four levels (SPL1, SPL2, SPL3, and Observation). SPL Supervision Conditions are summarized for each level, including standard. An Emergency Suicide Response Kit worksheet directs their effort to locating where the kit is located on their unit and to the supplies that should be contained in the kit. Finally, the trainee indicates when (date, time, location) they are scheduled to

attend the 8-hour Full Day Suicide Prevention Training.

**Observations:** The overarching approach taken here by JR is very clever and sophisticated from a training perspective. Specifically, staff are required to come to the full-day already prepared, where the basics are already known to them (e.g., they've memorized risk factors, read the policy, inspected the Emergency Suicide Response Kit). Presumably, this allows for a more thorough discussion of content, role play, and more thoughtful questions. Second, both staff and their supervisor are required to sign that they have actually *done* the task. Having the supervisor sign off is particularly smart – to ensure that in fact the tasks have been done and barriers to completion are known, solved. Finally, inclusion of the worksheets to direct their focus for what to observe during the initial SSS and their inspection of the Emergency Suicide Response Kit moves what could be a non-focused learning exercise to one that is focused on the relevant training objectives.

**SUICIDE AND SELF-HARM DESK MANUAL.** This 21-page document, last revised January 4, 2019, provides a brief summary of the JRA Policy 3.3.0 then detailed instructions for when/how to complete the SSS. Important reminders include: conduct the SSS in confidential, distraction-free environment with a goal of having the youth be a willing and truthful partner during the interview. Screen shots of the online form are included as instruction. To ensure effective administration of the SSS interview, instructions/suggestions for what to say are included as well as a therapeutic flow to the interview that includes thorough orientation to the process itself. Bolded text in a section entitled, “Structure of Youth Interview”, users are informed: “**The questions should first be asked as written.** If the youth does not understand, even after the question is repeated, reword the question...This is important because the SSS has been validated by Columbia University. Deviating from the original question could invalidate the tool.”

The flow of the SSS interview guides the user through the steps and helps frame the transitions from one section to the next: **INTERVIEWER: Now I want to ask you about self-harm and suicide. These questions are personal, but important. Some of these questions ask about ever in your life and some are about right now. Please ask me to clarify if you don't understand.**” Scripts for follow up questions and to validate the pain and difficulty of their experience are also included: **INTERVIEWER: If the youth answers yes, then say, “That must be hard for you”, or make other appropriate empathetic response.**

**Observations:**

1. The desk manual is well-organized, easy-to-use, and naturally follows the flow of the SSS interview. The Youth Self-Report interview scripts are clinically thoughtful and provide a novice clinician with the capacity to sound like a master clinician, as the youth is oriented to each section of questions with a sense of what to expect and empathetic responses are provided.
2. There are no scripts provided for the discussion with the youth's parent(s)/legal guardian, nor is there principle-based guidance for these calls beyond what is required by Policy 3.30.23.8 and Policy 1.40.16.
3. The recommended script includes use of “self-harm” and “suicide” - words that may be scary and off-putting to youth: **INTERVIEWER: Now I am going to ask you about self-harm and suicide. These questions are very personal but important to ask.** The SSS interview itself does not use this explicit language. Many times the questions are framed as they are in the SSS in more

descriptive (less categorical) terms: “In the past week, have you wished you were dead?” “Have you ever tried to kill yourself”, etc. The script might be revised to something more like:

**INTERVIEWER:** Now I am going to ask you about times in your life (or past week or now) when you wanted to or did harm yourself or wanted to end your life.

**SSS, SPL, & Supervision Condition Changes in ACT: Quick Info Sheet.** This three-page document highlights the changes made to the SSS in response to an audit by the National Commission on Correctional Health Care. The specific focus is on when and how the necessary approvals are strengthened. Three possible outcomes for review (by supervisor) of the SSS are noted: Approved, Denied, and Superseded. This latter outcome allows a supervisor to close the loop on previously submitted SSS that has since been revised/updated based on more current information.

**SSS/DSPS QA FORM (June 3, 2019).** This one-page six-item document is intended as a quality assurance check to ensure the policy and procedure is implemented routinely and accurately.

**Revised Prevention, Assessment and Understanding of Suicide (PAUSE) Trainer’s Manual: A curriculum developed for use in residential juvenile rehabilitation facilities in Washington State, November, 2018.** This 290-page document details the training curriculum for all aspects of the suicide prevention training plan (in compliance with Policy 3.30). The curriculum was developed initially in 2001 with assistance from national consultant Lindsay M. Hayes, PhD and has since been revised overtime by John T. Bolla, MS, CDP to stay current with current statistics and research. A number of the documents included in this curriculum (worksheets in preparation for 8-hour training) are included. The curriculum is comprehensive, highlights key points for trainer and provides very specific talking points to ensure training is standardized across training. True/False tests and myth/fact quizzes are included. Demographic data on JR Youth Suicides from 1990 – 2017 are reviewed.

## APPENDIX C: QUALIFICATIONS OF REVIEWER

Linda A. Dimeff, PhD, is Chief Scientific Officer at the Evidence-Based Practice Institute, Inc; Institute Director at Portland DBT Institute, Inc., and Clinical Faculty in the Department of Psychology at the University of Washington. Since 1994, Dr. Dimeff has collaborated closely with Marsha M. Linehan to develop and evaluate an adaptation of DBT for substance-dependent individuals with borderline personality disorder; to produce DBT training materials for clinicians; and to train, consult, and supervise clinicians in their practice of DBT. She has worked with public and private sector systems throughout the world in their efforts to implement DBT. Dr. Dimeff is a recipient of the Cindy J. Sanderson Outstanding Educator Award from the International Society for the Improvement and Teaching of DBT. Linda has received over 20 federal grants to facilitate the dissemination of evidence-based therapies and has published over 55 peer-reviewed publications. She is also the first author of *Brief Alcohol Screening and Intervention College Students*.